NOVA Medical School / Faculdade de Ciências Médicas

Universidade NOVA de Lisboa

Adapting the WHO QualityRights Tool for the prison setting

Master's dissertation in Mental Health Policy and Services

By

Louise Southalan

Supervised by:

Professor Graça Cardoso

September 2017

Declaration

I hereby declare that this thesis is the result of my own work under the supervision of Prof. Graça Cardoso and no part or its whole has been presented for award of a degree in this university or elsewhere.

STUDENT: LOUISE SOUTHALAN

SIGNATURE:.....

DATE: .....

SUPERVISOR: PROFESSOR GRAÇA CARDOSO

SIGNATURE:.....

DATE: .....

Acknowledgements

I wish to acknowledge the kind support and advice of my supervisor, Prof. Graça Cardoso, throughout the process of writing this dissertation. Participating in this academic program has been a wonderful experience. I have learnt a great deal and vastly expanded and improved my knowledge and perspective. This is due both to the excellent teaching provided, and also to the many fascinating, challenging and delightful interactions I have had with my fellow students. The administrative staff of the Faculdade de Ciências Médicas have been unfailingly helpful, patient and kind throughout the course.

I am very grateful to my employer, the Mental Health Commission of Western Australia, for supporting me to undertake the course. My supervisors and colleagues have provided invaluable encouragement, and I very much appreciate the confidence they have shown in me throughout this process.

I have been grateful for the interest and support of many family and friends. In particular I would like to acknowledge the thoughtful and meticulous feedback on draft versions of this dissertation provided by Mel Whelan and Tatum Burkett, which was so helpful.

Finally, and most importantly, words cannot adequately express my thanks to my husband John Southalan. Once again he has inspired me with his great capacity for kindness, thoughtfulness and hard work, all of which he brought to bear in so many ways that directly helped me during this course, and in particular in the writing of the dissertation.

Abstract

This dissertation considers a process through which rights and quality of mental health services are measured in non-prison settings, and explores how this can be adapted to prison settings. The World Health Organisation (WHO) QualityRights tool was developed to enable countries to qualitatively assess quality and rights aspects of mental health services, referenced against the *Convention on the Rights of Persons with Disabilities* (CRPD). The CRPD is premised on achieving substantive equality of human rights regardless of disability, and entrenches the principle of non-discrimination in the way that states are required to ensure equal rights for people with disabilities.

Whilst states are legally bound to provide prisoners with a level of healthcare equivalent to that provided outside prison, understanding what 'equivalent care' means is complex. There are many situations where prison procedures uniquely impact on people with mental disorders. Moreover, the higher prevalence and complexity of health problems in prisons arguably means that providing healthcare equivalent to that found in the community may fall short of what prisoners require, if assessed on the basis of equity of health outcomes. Several scholars in the field have suggested a need to move beyond the principle of equivalence because of its conceptual and practical challenges. However there is currently no clear consensus on how to reach a more workable understanding of the principle. To date consideration of the principle of equivalence has included little discussion of the implications of the CRPD.

This dissertation seeks to constructively engage with this debate by identifying, from the literature, issues in prison life which can impact significantly on the rights of people with mental disabilities. It proposes an adapted version of the QualityRights tool to incorporate these issues, subject to future refinement and piloting, and suggests areas for future research.

Key words:

mental health, prisoners, prison health, correctional mental health, QualityRights, principle of equivalence

Resumo

Esta dissertação considera um processo através do qual os direitos humanos e a qualidade dos serviços de saúde mental são avaliados em ambientes não prisionais e explora como esse processo pode ser adaptado às configurações prisionais. O instrumento QualityRights da Organização Mundial da Saúde (OMS) foi desenvolvido para permitir que os países avaliem qualitativamente os aspetos de qualidade e observação dos direitos humanos dos serviços de saúde mental, tendo como referência a Convenção sobre os Direitos das Pessoas com Incapacidade (CDPI). A CDPI tem como premissa básica alcançar a igualdade substantiva dos direitos humanos, independentemente da incapacidade, e estabelece o princípio da não discriminação na forma como os países devem assegurar a igualdade de direitos das pessoas com incapacidade.

Embora os países estejam legalmente obrigados a fornecer aos presos um nível de assistência médica equivalente ao fornecido fora da prisão, entender o que significa "cuidado equivalente" é complexo. Há muitas situações em que os procedimentos prisionais afetam de forma única as pessoas com perturbações mentais. Além disso, a maior prevalência e complexidade dos problemas de saúde nas prisões significa que o fornecimento de cuidados de saúde equivalentes ao encontrados na comunidade pode ser inferior ao que os prisioneiros exigem, se avaliado com base na equidade dos resultados. Vários estudiosos nesta área sugeriram a necessidade de ultrapassar o princípio da equivalência por causa dos seus desafios conceptuais e práticos. No entanto, atualmente não existe um consenso claro sobre como alcançar uma compreensão mais manejável do princípio. Até à data, a consideração do princípio da equivalência tem gerado pouca discussão sobre as implicações da CDPI.

Esta dissertação procura empenhar-se de forma construtiva neste debate, identificando, a partir da literatura, questões da vida prisional que podem ter impacto significativo sobre os direitos das pessoas com incapacidade mental. De forma a incorporar essas questões, este trabalho propõe uma versão adaptada do instrumento QualityRights sujeita, no entanto, a possíveis melhoramentos e a um estudo piloto e sugerindo também áreas para investigação futura.

Palavras-chave:

saúde mental, prisioneiros, saúde prisional, saúde mental correcional, QualityRights, princípio de equivalência

Resumén

Esta tesis considera un proceso mediante el cual los derechos humanos y la calidad de los servicios de salud mental se miden en contextos no penitenciarios, y explora cómo se puede adaptar esto a los entornos penitenciarios. La herramienta QualityRights de la Organización Mundial de la Salud (OMS) fue desarrollada para permitir a los países evaluar cualitativamente los aspectos de calidad y derechos humanos de los servicios de salud mental en referencia a la Convención sobre los Derechos de las Personas con Discapacidad. La CDPD se basa en el principio de la igualdad sustantiva de los derechos humanos, independientemente de la discapacidad, y refuerza el principio de no discriminación en la forma en que los estados deben garantizar la igualdad de derechos de las personas con discapacidad.

Mientras que los estados están legalmente obligados a proporcionar a los presos un nivel de asistencia sanitaria equivalente al que se proporciona fuera de la prisión, entender lo que significa "cuidado equivalente" es complejo. Hay muchas situaciones en las que los procedimientos penitenciarios tienen un impacto único sobre las personas con trastornos mentales. Por otra parte, la mayor prevalencia y complejidad de los problemas de salud en las cárceles significa que la provisión de asistencia sanitaria equivalente a la que se encuentra en la comunidad puede quedar inferior a la que los reclusos necesitan, si se evalúan sobre la base de la equidad de los resultados sanitarios. Varios especialistas en el campo han sugerido la necesidad de ir más allá del principio de equivalencia debido a sus desafíos conceptuales y prácticos. Sin embargo, actualmente no existe un consenso claro sobre cómo lograr una comprensión más viable del principio. Hasta la fecha, el examen del principio de equivalencia ha incluido poca discusión de las implicaciones de la CDPD.

Esta disertación busca involucrarse constructivamente con este debate identificando, a partir de la literatura, temas en la vida penitenciaria que puedan impactar significativamente los derechos de las personas con discapacidad mental. Propone una versión adaptada de la herramienta QualityRights para incorporar estos temas, sujetos a futuros perfeccionamientos y pilotaje, y sugiere áreas para futuras investigaciones.

Palabras clave:

salud mental, prisioneros, salud penitenciaria, salud mental correccional, QualityRights, principio de equivalencia

Contents

Chapter 1: Overview

The health of people who are incarcerated is an issue which is complex, large in scale, and of fundamental importance for human rights, public health and community values.

More than ten million people are imprisoned worldwide.[1] Prison populations are characterised by a high prevalence of serious and chronic health conditions.[2] In particular, research has consistently shown that prisoners[3] have much higher rates of mental disorders than in the general population, including serious mental illness.[4] In some countries more people with severe mental illness are in prisons than in psychiatric hospitals,[5] and a number of studies have mapped correlations between increased incarceration of people with mental illnesses and reductions in inpatient mental health services.[6] The scale of the issue is increasing globally, with a significant rise in imprisonment rates and total numbers of incarcerated people in the past two decades.[7]

Effective prison health care can play important social justice and public health roles. A consistent theme from the research is that prisoners are overwhelmingly drawn from poor and marginalised parts of society, typically with relatively low levels of education and employment experience and low levels of engagement with health services.[8] For some prisoners, prison can provide the first opportunity for a settled life with adequate nutrition and health interventions, and the potential impact of health services is high.[9] Further, nearly all prisoners return to the community. Returning with untreated conditions is likely to pose a threat to community health, add to the burden of disease, and increase the need for health and welfare services intervention, often in emergency contexts with high costs and consequences.[10]

---

[1] The actual figure is likely to be closer to 11 million as no reliable figures are available for North Korea, and figures relating to China do not include remand prisoners: Coyle & o'rs 2016, 9.
[2] Gatherer & o'rs 2014, 2-4.
[3] In this dissertation the term 'prisoners' is used to encompass all persons who are sentenced or remand detainees in correctional facilities, noting that within some jurisdictions further categorisation is made between jails, prisons, penitentiaries, lockups and work camps, at times with distinct terminology.
[4] Fazel & o'rs 2016.
[5] Fazel & o'rs 2016.
[6] See for example Steadman & o'rs 1984; Hatton & Fisher 2008; Teplin 1983.
[7] Coyle & o'rs 2016, 37.
[8] Baybutt & o'rs 2014, 180-181.
[9] Gatherer & o'rs 2014, 2-4.
[10] Gatherer & o'rs 2014, 2-4.

States have agreed at international level to provide prisoners with equivalent levels of health care to that provided in the community. As is discussed in Chapter three, this principle of equivalence is stated and reinforced throughout the international instruments. Yet relatively poor prison healthcare appears to be common worldwide. While there are gaps in the evidence base, numerous examples of clearly inadequate prison health services across both rich and poor countries have been identified.[11] These have at times highlighted systematic failings in prison health care, some of which have been judged to amount to cruel, inhuman and degrading treatment, as is discussed further in Chapter three.

Although prison mental health care is clearly a significant public health and human rights issue, it has not been the focus of particular attention within the broader reforms represented by the Movement for Global Mental Health.[12] This may be because of the sheer complexity of the challenges of providing effective and efficient mental health care to incarcerated populations. One of these challenges is how to ensure that prison mental health care is delivered in a way which supports a human rights approach to health, rather than in a way that reinforces the notion of punishment. A further challenge is how to define a clear basis for the standard of mental health care to be provided in prison, given that key health determinants are different in prison settings compared to other settings. The issues have been further complicated by the fact that historically prisons have generally operated somewhat at a remove from general health and mental health services, often with distinct service providers and lines of accountability.

This dissertation considers a process through which rights and quality of mental health services are measured in non-prison settings, and explores how this could be adapted to a prison setting. The World Health Organisation (WHO) QualityRights tool was developed to provide a means for countries to qualitatively assess quality and rights aspects of mental health services, referenced against the requirements of the Convention on the Rights of Persons with Disabilities (CRPD).[13] The CRPD is premised on the need to achieve

[11] See for example Woodall & Dixey 2017, 58-61; Lines 2006; Lines 2008. In addition examples are regularly considered in reports by the Special Rapporteurs for Torture and for the Right to Health, see for example UN 2016c; .UN 2016b

[12] For discussion of the Movement for Global Mental Health see, for example, Patel & o'rs 2011; Patel 2012; Wainberg & o'rs 2017.

[13] *CRPD* (2006).

substantive equality of human rights, and entrenches the principle of non-discrimination in the way that the state ensures access to rights.

It is important to note that within this dissertation both the terms 'mental disability' and 'mental disorder' are used interchangeably, with the intention that both have the broad meaning used within the CRPD. Under Article 1 of the CRPD 'people with mental disabilities' includes those with mental, neurological or intellectual impairments and those with substance use disorders.

The QualityRights tool was designed for use in a variety of mental health services, both inpatient and community, in rich and poor countries, with the intention of enabling comparisons between services within a jurisdiction. It addresses five themes, reflecting core aspects of the CRPD relating to the situation of people with mental disabilities receiving services:

- The right to an adequate standard of living;[14]
- The right to enjoyment of the highest attainable standards of physical and mental health;[15]
- The right to exercise legal capacity and the right to personal liberty and the security of person;[16]
- Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse; and[17]
- The right to live independently and be included in the community.[18]

Each of the themes within the QualityRights tool is broken down into a series of 'standards', although framed in relatively subjective terms. The tool is designed to be a pragmatic, qualitative instrument, to be used collaboratively by a team of multi-stakeholder reviewers, and to result in a snapshot view of the level of compliance by a service with key rights within the CRPD. It also enables the identification of possible areas for reform. The

[14] *CRPD* (2006), art 28.
[15] *CRPD* (2006), art 25.
[16] *CRPD* (2006), arts 12 & 14.
[17] *CRPD* (2006), arts 15 & 16.
[18] *CRPD* (2006), art 19.

methodology is comparative, so that in considering a mental health service, an assessing team also reviews a comparable general health service. Under the tool, facilities are assessed through interviews, observation and reviews of documentation to allow reviewers to determine whether a particular standard, and in turn a theme, has been met.[19]

This dissertation explores the challenges of adapting the QualityRights tool for use in prison settings, and proposes an adapted version of the tool. The specific research question being addressed is:

> *How can the WHO QualityRights tool be adapted for the prison environment in a way that appropriately recognises the impact of the prison setting on imprisoned people with a mental disability?*

1.1 Background to the question

Whilst states are legally bound to provide prisoners with a level of healthcare equivalent to that outside prison, understanding what 'equivalent care' means is complex. Through the adaptation process this dissertation seeks to explicitly identify areas of prison life which tend to have a significant impact on rights of people with mental disorder, and which may not be recognised in measures of equivalence adopting an outcomes focus.

A tension is embodied in the requirement of states to provide equivalent levels of service with the recognition that prison settings are inherently different. Some analysis suggests that because of the essential differences of the prison population and setting, equivalence to community *per se* is not in fact possible; as health is a function of underlying environmental and social determinants and is underpinned by ethical and relational conditions, all of which differ fundamentally in prisons.[20]

Others have argued that equivalence only makes sense if it is calculated in terms of health outcomes,[21] providing a distinction between equivalence and equity. This difference is described thus by the Association for the Prevention of Torture:

---

[19] WHO 2012a, 6.

[20] See, for example, Jotterand & Wangmo 2014b; Jotterand & Wangmo 2014a. The issue is further discussed in, for example, Junewicz 2014; Birmingham & o'rs 2006; and Niveau 2007.

[21] Lines 2006. He further contends that the international jurisprudence supports such an elevated duty for prison health services: Lines 2006, 276.

> *Equivalence means that detainees receive at least the same level of health care as those in the community. In this way national health policies, programs and protocols will be applied equally in prisons as in the community. But since the prison population is usually composed of marginalised and vulnerable individuals who are at higher risk of mental and physical illness, physical and sexual violence and substance dependency amongst other things, the prison population often has greater health needs. It is therefore usually the case that prisons require greater attention to health care, and more resources need to be directed to where the problems are greatest. This is termed equity of healthcare.*[22]

On this argument, the higher prevalence and complexity of health problems in prison means that achieving standards equivalent to those found in the community would, in some cases, fall short of human rights obligations and public health needs.[23] This implies, as Lines argues, that it is not equivalence of standards as such that is required, but standards that meet equivalence of outcome.[24]

To some extent this approach is premised on the assumption that it is possible to create a meaningful distinction between outcome and process. In some situations this approach makes sense, as illustrated for example by Charles and Draper's description of the perverse consequences which can arise from interpretations of equivalence in which similarity of process is over-valued. They argue that this can create a 'superficial appearance of equity while allowing inequities between the health of prisoners and non-prisoners to remain unrecognised and unchallenged', as in the following example:[25]

> *Extremely high rates of drug misuse and communicable disease exist within prisoner populations. Consequently, a prisoner placed on the central methadone waiting list is at a greater risk than a non-prisoner of contracting blood-borne diseases while on the list, the risk being compounded by the high prevalence of needle sharing in prisons because of the absence of needle exchange schemes. This discrepancy is not captured when equivalence of process is measured, giving a false impression of equity where the waiting periods are roughly similar. Instead, the use of outcome measures may highlight an inequity that can best be*

[22] APT ud-a.
[23] See, for example, Niveau 2007.
[24] Lines 2006.
[25] Charles & Draper 2012.

> *addressed by using different processes – for example, the introduction of a fast-track waiting list for methadone treatment in prisons, or a more stringent vaccination program to prevent the spread of infectious diseases between intravenous drug users.*

However in this dissertation it is argued that it would be a mistake to ignore process elements. Prisons are places where practical judgments as to the balancing of rights and interests are made on a daily basis, in an environment where one group exercises a considerable amount of power over another, highly marginalised group.[26] The fact that prisons are total institutions, in the sense described by Goffman,[27] where prisoners are entirely dependent on prison administrators for services, means that process and procedure take on great significance.

There are many situations where prison procedures can impact on people with mental disorders in ways that will not be relevant in non-prison settings. An obvious example is the way prisoners are screened and classified. Huber et al note that prison risk assessments often interpret prisoners' needs as 'risk factors', resulting in various prisoners being classified at a higher level and therefore subjected to more restrictive regimes. This is often the case for prisoners displaying symptoms of depression or other mental illnesses, which can result in greater isolation for these individuals.[28]

This is of particular significance in those prisons where the traditional model of security prevails. The traditional model of prison security emphasises physical (perimeter and facilities) and procedural (such as classifications, rules around movement and restrictions on contact) elements. More contemporary notions of dynamic security recognise that respect and fair treatment play essential roles in creating safe prisons.[29]

It is also not clear that a clean distinction between process and outcome can always be drawn, particularly in prison mental health, depending of course on how one defines 'process'.[30] Issues such as waiting times, access to medications and specialist services, use

[26] Edney 2001.

[27] Goffman's seminal notion of a total institution is that of 'a place of residence and work where a large number of like-situated individuals cut off from the wider society for an appreciable period of time together lead an enclosed formally administered round of life': Goffman 1961.

[28] Huber & o'rs 2015.

[29] UN 2015.

[30] In any event, different writers appear to have quite different concepts in mind when referring to process compared to outcome in prison healthcare, eg Charles & Draper 2012; Jotterand & Wangmo 2014a; Hurst 2014.

of bodily restraint, relationships of trust with clinicians, and continuity of care would all seem to encompass both process and outcomes. Given the difficulty of cleanly separating process and outcomes, and the potential for greater influence over process, it may be that focussing on process to produce the desired outcomes will be more beneficial than focussing on outcomes or process equivalence in isolation.

The CRPD sharpens the question of what level of healthcare states are obliged to provide for prisoners with mental disabilities, which as noted above includes mental illness. The CRPD obliges states to remove discriminatory obstacles to full enjoyment of rights, including by making reasonable accommodation. This arguably parallels the obligation to provide an equivalent level of care, although allows for a more nuanced interpretation through recognition of reasonable accommodation.

Accordingly, it is suggested that tools applying the CRPD have much to offer the vexed question of the required level of healthcare in prisons. The QualityRights tool differs from most monitoring tools used in prison settings[31] in that it has not been designed specifically for a prison setting. The adaptation process itself therefore requires some assumptions underlying such a tool to be made explicit, which process itself entails examination of the underlying differences between prison and community.

It is intended that the process of adapting the QualityRights tool for prisons will achieve the following purposes:

- Provide a means of identifying and exploring aspects of prison life, particularly process elements, which are different to non-prison life, and which have potentially discriminatory impacts on prisoners with mental disabilities.
- Offer a means by which prison authorities can practically review some of the key areas where they may be non-compliant with the requirements of the CRPD.
- Facilitate greater transparency of the impacts of prison process decisions on the rights of people with mental disabilities. This is intended to counteract the

[31] See, for example, UN 2016a; PRI & APT 2015; Markov & Doichinova 2014.

traditional tendency for prisons to receive less oversight than other public services dealing with vulnerable populations.[32]

1.2 Research philosophy and limitations

This dissertation is written from an interpretivist epistemological position, founded on a subjectivist ontology. That is, the research question and response have been shaped by assumptions that the realities of prison life and criminal justice are socially constructed by the actors involved, and that social roles are fundamental to understanding the operation and role of prisons, laws, policies and processes.

The axiological stance of the research is one of social justice, in that the author holds values that it is desirable that the state take an active role in reducing inequalities through the laws and policies of criminal justice administration. This research stance has been informed by the author's workplace experiences as a public defence lawyer and a government worker commissioning prison mental health services.

The methodology adopted was a desktop analysis of the literature to identify situations where prisoners with mental disabilities were identified as experiencing treatment or conditions less favourable than those of prisoners without mental disabilities, or who received less favourable access to health services than that of people with mental disabilities who were not in prison. The issues identified were then analysed to consider how they relate to the framework of the five themes of the QualityRights tool. The intention through this process was to create a new version of the QualityRights tool which specifically reflects issues identified as having particular impacts on prisoners with mental disabilities, and which could highlight areas where unrecognised discrimination may be occurring.

This approach has enabled the adapted version of the tool to be produced in a relatively short period of time and to identify areas of useful further research. There are, however, a number of limitations to the research approach. These relate primarily to the narrowness

[32] It is notable, for example, that in a range of countries, judicial reluctance to intervene in the decision making of prison administrators has been expressly grounded in legislation and legal doctrine. The result has been a tendency (albeit lessening in some regions, namely Europe) to defer to the expertise of prison administrators, on the grounds that the prison environment is a unique and specialised one. This issue is discussed further in Morris & Rothman 1998, Harding 1998; Perlin & Dlugacz 2009; Edney 2001; and Rodriguez 2007.

of the literature from which the issues were drawn, and subjectiveness and lack of stakeholder input regarding decisions regarding both issue selection and adaptation of the tool.

The literature from which the issues were identified was only in English, and shows a distinct geographic skew, with wealthy Anglosphere countries such as the United States, United Kingdom, Australia and Canada being heavily over-represented. A limited range of perspectives was also represented in the literature, with a significant over-representation of health researchers as opposed to researchers from other disciplines. The perspectives of administrators, general prison staff, people with lived experience, and prisoners generally were significantly under-represented in or entirely absent from the literature.

A further limitation is that the process by which issues were identified as relevant and significant enough for inclusion was a subjective one which reflects the author's priorities and values. This selection process was not tested or validated through input by others with experience of receiving, working in or otherwise engaging with prison health services. It is of particular note that the selection of issues was made in the absence of input from people with lived experience of the issues, given that the intention of the selection process was to identify issues particularly impacting on those people. The decisions involved in interpreting the issues, and in developing the adapted tool, were similarly not subjected to alternative perspectives and input, and were made on a subjective basis by the author.

These limitations may be partially addressed in further work to develop the adapted tool, through seeking comprehensive input from stakeholders representing different perspectives, experiences, disciplines and geographic, cultural and economic backgrounds. It is envisaged that such a process would be a necessary preliminary step before validation and piloting of a refined version of the adapted tool.

1.3 Structure

The remainder of the dissertation is structured as follows:

- **Chapter Two** is a literature review.

- **Chapter Three** reviews the specific international human rights protections for prisoners and the application and approach of the CRPD.
- **Chapter Four** sets out the approach taken to the adaptation of the QualityRights tool to the prison setting, and considers aspects of the prison setting in Themes 1-2 which have the potential for significant discriminatory impact on prisoners with mental disabilities. An adapted version of the tool is proposed for Themes 1-2.
- **Chapter Five** considers aspects of the prison setting in Themes 3-5 which have the potential for significant discriminatory impact on prisoners with mental disabilities. An adapted version of the tool is proposed for Themes 3-5.
- **Chapter Six** sets out concluding remarks and a consideration of next steps.

1.4 Conclusion

The adapted tool presented and discussed in Chapters four and five represents an attempt to engage constructively with a contested area, albeit on the basis of a limited evidence base. The adaptation process has highlighted some of the complexities of the issues and identified some areas for potential future research, as is discussed further throughout the dissertation and in the conclusion.

Chapter 2: Literature review

The research question is:

> *How can the WHO QualityRights tool be adapted for the prison environment in a way that appropriately recognises the impact of the prison setting on imprisoned people with a mental disability?*

The areas identified as in scope in the literature review are the prison as a setting for health care and health services, and the impacts of the prison setting on people with mental disabilities. The literature considered for this literature review was identified from English language searches of PubMed, Google Scholar and OneSearch using search terms of 'correctional mental health', 'healthy prisons', 'prison mental health' and 'corrections mental health'. Considerable substantive grey literature was also identified through online searches.

It should be noted from the outset that there are distinct limitations to the literature derived from the search. It is characterised by its high over-representation of studies from high income countries, and a very high over-representation of adult males as subjects of research, to the exclusion or under-representation of other groups. There is a dearth of robust international comparative data about governance and standards, although it is expected that in late 2017 the WHO (Europe) Health in Prisons Program (HIPP) will publish the results of the first standardised regional survey of prison health systems, undertaken across the WHO Europe region.[33]

Whilst most prison health research has been at country-level within rich countries, some global comparative research has been undertaken. Notable amongst this are the studies of prevalence by Fazel et al, indicating that high prevalence of mental illness and poor general health is a consistent theme across all countries. Frequently international comparative prison health research focuses on small groups of countries, likely reflecting the difficulties of undertaking research with these populations and institutions, particularly in the absence of common indicators.[34]

---

[33] Personal communication to the author from L Moller (Director, WHO Health in Prisons Program), August 2017.
[34] Examples of the international prison health include Lines & o'rs 2009; and Dolan & o'rs 2007.

Lines[35] reviewed the evidence from a perspective of the human rights aspects of health in prisons internationally, which indicated that poor environmental conditions and inadequate levels of treatment are common. Other findings strongly supported by the evidence are that incarcerated people are overwhelmingly from poor, marginalised populations.

A key theme apparent from the literature is the different perspectives on the issue of how to take account of the prison setting in understanding and measuring prison health services. One of the major strands of this debate is the extent to which prisons can constitute health promoting institutions.

Key instigating factors in the development of the idea of health promoting prisons were the 1981 WHO Policy *Health for All by the Year 2000*, with its focus on health equity, and the 1986 *Ottawa Charter for Health Promotion*. Increased attention has been paid to the role of institutions such as prisons in health promotion in the three decades since. At the centre of the debate is the work generated by the HIPP, which commenced in 1995 and is supported by 28 European governments. In addition to its own publications, the HIPP has assembled and coordinated a broader body of academic research, which has resulted in greater systematisation of the research. HIPP has taken a health promotion and settings approach, which sees health as a function of underlying environmental and social determinants, and underpinned by ethical and relational conditions. The related 'healthy prison' notion is founded on an ecological model of public health, reflecting a systems perspective. This notion posits that as the health of prisoners is dependent on the ethos and regime created in the prison setting, it requires a whole-organisation focus on health and well-being.[36]

This concept has been met with different responses, albeit with an apparent consensus as to the importance of the prison setting to the health of prisoners, the complexities of practical application of the healthy prisons concept, and acceptance of the need for further research.[37] Jordan,[38] for example, reviewed the literature relating to prison culture, which is primarily United States-specific, and considered the issue in the context of United

[35] Lines 2006 and Lines 2008.
[36] See for example Enggist & o'rs 2014; UNODC & WHO 2013; Møller & o'rs 2012.
[37] Santora & o'rs 2014.
[38] Jordan 2011.

Kingdom settings-specific initiatives, such as the Enabling Environments projects and the Psychologically Informed Planned Environments pilot programs. She concluded that the complexities were considerable, and that future research was needed to understand the issue.

A sceptical perspective on the notion of the healthy prisons concept has emerged, primarily from British researchers taking a critical health promotion perspective. Smith[39] notes that the main aims and practices of imprisonment, featuring high levels of control and surveillance, are not consistent with the central concepts for health promotion, involving autonomy, self-esteem and empowerment. She casts doubt on the viability of the healthy prison model in light of, for example, the difficulties of promoting personal empowerment in prison, and the inherent tensions about how health matters are defined and responded to. She notes tensions between whether illicit drug use would be considered a health or security issue under a health promotion model, and a similar tension between the security or health-based responses to prisoners with mental illness. Smith also speculates that a health promotion paradigm may have the unintended consequence of promoting those behaviours sought to be minimised, noting that people with few alternative avenues of pleasure can gain additional release by indulging in behaviours labelled as 'deviant'.

Similar critiques arguments are presented in the work of de Viggiani[40], whose critical ethnographic work led to the conclusion that health inequalities are enmeshed within the workings of the prison system itself, and that the HIPP notion of a 'healthy prison' is therefore an oxymoron. Woodall[41] has similarly expressed scepticism of the concept of health promotion in prison, noting the inconsistencies between health promotion and the lack of autonomy of prisoners within typical prison regimes. Woodall also focuses on the apparent lack of support for the implementation of the health promoting prison model, which he argues may reflect an underlying weakening of commitment to the concept.

The elements of choice, control and empowerment were considered in depth by Woodall, Dixey and South,[42] who argue that these elements, which are central to health promotion

[39] Smith 2000.
[40] De Viggiani 2007.
[41] Woodall 2016.
[42] Woodall & o'rs 2014.

discourse, are crucial for the success of a settings approach to prison health. They interviewed male prisoners and prison staff in three prisons in England, and their analysis suggests that prisoners negotiate norms and structures of prison life by exercising resistance and choice, and by both taking and relinquishing control.

Baybutt and Chemlal[43] consider horticulture as an example of how more health promoting prisons might function, as it offers an illustration of how the prison setting can be more connected across the system, in a potentially more salutogenic manner. The benefits of horticulture to prisoners' mental health and the prison environment are also considered, through interviews with prisoners in England and France.

An important sub-theme emerging from the literature is the validity and applicability of the principle of equivalence in prison health care. Whilst the principle is entrenched within international human rights law, there is considerable debate and some disagreement about the its conceptual and practical implications. That the principle has limitations and is complex to apply receives general acknowledgement. However differences are apparent regarding the question of what the appropriate measure and standard for prison health care should be, and how this relates to the principle of equivalence.

A number of clinical researchers in the United Kingdom have provided valuable reflections on the conceptual and practical challenges to the principle of equivalence in light of the United Kingdom process of transferring responsibility for prison health to the National Health Service, with an explicit policy requiring equivalence in health care. Notable examples include Wilson[44], who described the clinical, ethical and practical challenges posed by such matters as the higher morbidity of the prison population, and the complexities and differences of the prison environment.

Birmingham et al[45] similarly consider several apparently insoluble dilemmas involved in application of the principle, and note that guidelines for good medical practice will not always reflect the nature and complexity of the ethical problems that arise or the reality of the prison environment. They speculate that, in light of this, perhaps the most important

[43] Baybutt & Chemlal 2016.
[44] Wilson 2004.
[45] Birmingham & o'rs 2006.

fact for clinicians to appreciate is the existence of overall ethical dilemmas in prison medicine and the fact that often no simple solution is available.

This key role of clinical staff in both constructing and managing the complexities of equivalence has also been considered, for example, by Wright et al.[46] Their qualitative work with prison health staff identified the important role of social relationships and informal networks rather than formal healthcare procedures for managing prisoners' mental health needs within the prison setting. They note the complexity this adds to the notion of equivalence, and that greater insight would be likely if the realities of frontline mental health work could be more fully taken into account in research and practice. Wright et al recognise the importance of process in understandings of equivalence, providing a contrast to a strict emphasis on outcomes evident in the work of other scholars, as discussed below.

Several scholars argue that equivalence to community is best considered a minimum level, and that the appropriate standard should rather be conceptualised as one of equity of outcomes, assessed according to the higher level of clinical need within prisons. A central pillar of this argument is the work of Lines.[47] Lines does not argue that equivalence should be dispensed with as a concept, but contends that it is only a minimum acceptable standard, rather than an ideal one. He argues that governments have legal and ethical obligations to provide prison healthcare to a higher standard than that available in the community, given the scope and urgency of the issues involved. In his 2008 work[48] Lines proposes addressing the issue in practice through the development of a monitoring mechanism under the auspices of the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment.

Niveau[49] reaches a similar conclusion as to the principle representing a minimum standard only, and gives particular consideration to the process and environment aspects of mental health in the prison setting. In addition to disparities in health needs and health profiles of the prison population, he notes the impact of such issues as higher service demand, and the consequent impact on the required clinical response. He also considers the complications

[46] Wright & o'rs 2014.
[47] Lines 2006.
[48] Lines 2008.
[49] Niveau 2007.

surrounding autonomy and consent, pressures on the therapeutic relationship, and the importance of relationships and environment for maintaining and improving mental health. He reaches the view that equivalence of care is impossible in psychiatry, firstly because prison constitutes an environment detrimental to mental health, and secondly because a prison doctor can never provide what is most needed for positive mental health - matters such as stable family or emotional relations, fulfilling work and liberty.[50] Despite Niveau's strong position on the impossibility of equivalence, he does not propose a radically different standard in its place, but rather, similarly to Lines, that where deviation from the principle of equivalence is inevitable, the response should be to exceed community standards, and never to fall short of them.[51]

Charles and Draper reach a similar conclusion, however argue strongly that equivalence should entail a focus on health outcomes, rather than processes. They make an explicit distinction between outcomes and process, and argue that considering equivalence in terms of process rather than on the basis of outcome can have the consequence of prisoners receiving a lower standard of care. Charles and Draper propose an outcomes-focused approach to equivalence and suggest that this be modelled on the United Kingdom's approach to education of children with special educational needs, which requires the achievement of equity in education. They compare the resultant integration of children with special educational needs into mainstream schools with the process of the integration of prison health services into the National Health Service, and suggest that the educational integration process has differed to the prison health integration by its greater focus on equivalence of educational outcomes. "The achievement of children with special educational needs is monitored, and, where it falls below that of their peers, alternative provision is made—for example, in the form of an adapted curriculum or specialist teaching."[52]

They suggest that the application of this educational model to prison healthcare may enable greater equity to be achieved, by monitoring health outcomes of prisoners compared with those of the general population and addressing discrepancies by altering healthcare

[50] Niveau 2007, 611.
[51] Niveau 2007, 612.
[52] Charles & Draper 2012, 218.

processes, rather than through equivalence of process inside and outside prison. This approach sees process as a tool in the service of equitable outcomes, with outcomes providing the core content of health.

By contrast, Junewicz[53] brings a specific focus to the centrality of process in its own right. She extends the discussion of equivalence to the treatment of prisoners in hospitals outside of prisons, and considers in particular the practice of shackling prisoners in these circumstances, which she argues mitigates against equivalence and infringes on rights and dignity. She concurs with the desirability of including equivalence of outcomes as a goal of prison medicine, in both prison and hospital settings. She notes the difficulties of achieving this in both prison environments, and suggests that a more reasonable goal in the hospital environment may be equivalence of process, given that prisoners and the public both receive treatment there. She argues that while a policy and practice of shackling prisoners in hospitals is in place, along with privacy violations, equivalence of process is impossible.

Other proposals for moving beyond the principle of equivalence have been explored in recent years, including by Exworthy, Till and others in the United Kingdom. Exworthy et al[54] specifically consider prison psychiatry in the United Kingdom following a decade of experience under a policy of equivalence. They suggest there is a need to move well beyond equivalence, and that finding a robust alternative is a key priority in addressing what they see as a continued shortfall in prison health care provision. Their proposal is to develop more appropriate indicators for prison health based on the four components of the AAAQ framework,[55] which they argue are better capable of recognising the unique nature of the prison population and setting. They suggest that the AAAQ framework would be compatible with the existing independent monitoring standards of prisons in the United Kingdom assessing safety, respect, purposeful activity, and resettlement.

Similarly Till et al[56] concur with the view that equivalence is a minimally acceptable standard, rather than an ideal one and support the suggestion that the AAAQ framework provides a useable framework for the development of new and improved indicators. They

[53] Junewicz 2014.
[54] Exworthy & o'rs 2012.
[55] The AAAQ Framework consists of four dimensions, Availability, Accessibility, Acceptability and Quality.
[56] Till & o'rs 2014.

advocate a move beyond the concept of equivalent standards towards equivalent objectives, irrespective of the range and quality of services.

Separately a rich debate has taken place in the *American Journal of Bioethics* with Swiss and United States-based scholars, launched by a proposal by Jotterand and Wangmo.[57] They draw on the work of Smith, Niveau and Charles and Draper and agree with the proposition that equivalence is neither realistic nor achievable, as it compares two different settings and two distinctive populations without a basis for comparison that contextualizes health determinants. They identify a barrier to progress as lack of clarity of concepts, and propose a pragmatic solution which appears to imply the need to dispense with the principle of equivalence. They suggest an alternative focus on what is needed to improve health care delivery in an environment acknowledged as being detrimental to the promotion of healthy behaviour. They argue for a reconceptualization of what health means in the prison context, as being "well-functioning in prison", and the development of a framework in which diseases are seen as clinical problems with interventions developed specifically for the prison context.

This proposal prompted a number of responses. An interesting rebuttal to the Jotterand and Wangmo proposal has been framed by Hurst[58], who argues that the proposal has lost the central tenet that health in prison is just as important as health in the general population, and implies or risks an acceptance of both a lesser level of health for prisoners and lower ethical standards by clinicians. To the argument that there is confusion around what equivalence means, she argues that it is preferable to accept lack of clarity in the concept of equivalence than to seek to replace the concept with a lower standard, noting that 'health' itself is an unclear concept in all areas of health care.

Dober[59] critically considers the practical implications of Jotterand and Wangmo's proposal in the United States context. Despite concurring from a theoretical standpoint, he argues that it would not be pragmatically achievable in the United States. He cites factors related to the American decentralized prison system, the plethora of agencies with responsibilities for the standards and delivery of care, both government and private, and the complex legal,

[57] Jotterand & Wangmo 2014a.
[58] Hurst 2014.
[59] Dober 2014.

financing and administrative arrangements for prison health care, with incentives which often mitigate against equivalence. Despite Dober's scepticism, however he recognises benefits in the proposal, as helping to focus the gaze upon prisoners themselves in their specific circumstances, and proposes a compromise position. He suggests that any reconceptualization of the notion of health as "well-functioning in prison" be supplemented with clear criteria, to include those health risk factors traditionally conceived in the notion of health. He contends that this would the reduce risk of neglect of prisoners' health in an unfriendly environment, while enabling a medical care program specifically for prisoners.

In their subsequent response to the debate, Jotterand and Wangmo[60] assert that they were not advocating the replacement or the abandonment of the principle of equivalence, but rather intended to reassess the utility and applicability of the principle. They state that while they think equivalence is unachievable, they recognize it as the primary guideline for the provision of health care to prisoners. Thus it appears that the width of this particular debate may not be so great as appeared. Jotterand and Wangmo do confirm one area of difference from Hurst, however, in that they hold that clear definitions of the concepts of health and disease are necessary, and are in fact a prerequisite, to meeting the health needs of prisoners. They contend that without this the principle of equivalence remains obscure and falls short of reaching its goal.

Thus the academic debate at present appears to have reached a rough consensus that the principle of equivalence is an unrealistic and unachievable standard, and yet there is reluctance to depart from it. The recognition by researchers that the prison setting and cohort demand setting-specific standards is counterbalanced by a reluctance to accept a different standard, in the fear that acceptance of 'different' will be applied as 'lesser', leading to a formalisation of lesser standards for prisoner health. This is not an unreasonable fear when one considers the history and the current state of prison conditions, and the frequently much lower level of health care provided to prisoners than other citizens. There is, in any event, no clear direction for how an alternative (whether expressed as 'greater

[60] Jotterand & Wangmo 2014b.

clarity', 'better standards' or a 'reconceptualisation of the notion of health') would relate to standards of healthcare in the community, if at all.

It seems that this dilemma will only be resolved if setting-specific standards also clearly embody underlying principles of equity and non-discrimination, and are developed consistently with human rights treaty obligations. Such an idea lies behind the suggestion of Exworthy et al that the AAAQ framework be used to develop prison-specific health indicators. It is also consistent with an approach which ties the principle of equivalence to the legal concept of substantive equality, present within disability discrimination law and also within the CRPD.

The impact of the CRPD and its obligations on states has, however, been largely notable by its omission from the scholarly debate. This is despite the fact that the CRPD applies in prisons, obliging states to ensure that the right to health, for example, can be enjoyed on a non-discriminatory basis by people with mental disabilities. As is discussed in Chapter three, the CRPD Committee has specifically considered states' obligations to prisoners under the CRPD in the context of specific complaints by people with disabilities in prison alleging breaches of the Convention.

Perlin and Dlugacz[61] noted the dearth of scholarly consideration of the role of the CRPD on the situation of prisoners with mental disabilities in their 2009 review of the legal scholarship and decisions in the United States, and the situation has hardly changed since then. They reach the view, however, that even within the United States, where the CRPD remains unratified, it is likely to be of considerable significance for the rights of prisoners with mental disabilities. Perlin and Dlugacz consider that the CRPD principles should serve as "a model of best practice for all future inquiries into the rights of prisoners to adequate mental health care and treatment," in the manner of the Convention on the Rights of the Child in previous United States litigation, and identify the CRPD as a potential blueprint for litigators looking for "fresh approaches to the seemingly intractable constellation of legal and behavioural issues faced by prisoners with mental disabilities."

[61] Perlin & Dlugacz 2009.

Whilst not specifically considering the impact of the CRPD, Schlanger[62] provides a comprehensive consideration of the practical application of US domestic disability rights legislation in a prison setting. This legislation was the foundation for, and in many respects mirrors, the CRPD. Schlanger finds that the key implication for administrators is that they must individualize their assessments of and responses to prisoners with disabilities.

One of the benefits of incorporating the insights of disability discrimination legislation and the CRPD into the debate about the principle of equivalence is that it may provide a means of moving through the conceptual challenges relating to process and outcomes. The CRPD draws on a heritage of legal scholarship around the notion of substantive equality, which is discussed further in Chapter three.

The research in this dissertation is intended to make a modest contribution to this identified gap in the literature, at the point where the CRPD interacts with the principle of equivalence, via the practical application of the QualityRights tool.

[62] Schlanger 2017.

Chapter 3: Prisoners' rights and the CRPD

As the literature review has shown, the principle of equivalence is both important and contested within the scholarship. This chapter considers how the principle is entrenched within the key international human rights instruments, and provides examples of its interpretation within international human rights cases. It then considers the application of the CRPD and its approach of substantive equality to the prison health setting. The Mandela Rules and recent decisions of the CRPD Committee are considered as examples of the coalescing of the principle of equivalence and the notion of substantive equality in the area of prison mental health.

3.1 Rights protections for prisoners and the principle of equivalence

The premise for prisoners' human rights is set out in the UN Basic Principles for the Treatment of Prisoners:[63]

> *Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners/ detainees shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and, where the State concerned is a party, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants.*

Being sentenced to imprisonment clearly inherently entails the restriction or limitation of some human rights, in particular liberty and freedom of movement. However aside from the human rights lost or modified by imprisonment, prisoners retain their human rights, including the right to the highest attainable standard of health (or simply 'the right to health').[64] Non-discrimination is a key principle in human rights constructs, and has direct implication for the enjoyment by prisoners, including those with mental disorders, of the right to health on an equal basis.

[63] UN 1990.
[64] UN 1990; UN 2008; Naylor 2014.

Also crucially for prisoners' health, the Committee on Economic, Social and Cultural Rights[65] has determined that, notwithstanding resource constraints, certain undertaking by states under the International Convention on Economic, Social and Cultural Rights have immediate effect. One of these is to guarantee the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups, and the equitable distribution of all health facilities, goods and services.[66]

International human rights law does allow for legitimate limitations, derogations and reservations to human rights. However certain basic human rights apply at all times, without derogation, even in exceptional situations, including the prohibitions against torture or cruel, inhuman and degrading treatment. Breaches of these prohibitions are not justifiable under any circumstances.[67] The international jurisprudence, particularly from the most developed regional human rights mechanism, the European Court of Human Rights, is clear that denial or restriction of healthcare to prisoners may amount to torture or cruel, inhuman and degrading treatment.[68]

International human rights instruments contain a number of protections and standards specifically relating to the rights of people in detention. Article 10 of the International Covenant on Civil and Political Rights (ICCPR) provides that "all persons deprived of their liberty should be treated with humanity and with respect for the inherent dignity of the human person." The UN Human Rights Committee,[69] considering Article 10, has affirmed that:[70]

---

[65] The two earliest, and the fundamental, UN human rights conventions are the *International Convention on Economic, Social and Cultural Rights* (*ICESCR* (1966)) and the *International Covenant on Civil and Political Rights* (*ICCPR* (1966)). Both entered into force in 1976. The Committee on Economic, Social and Cultural Rights is the body of independent experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights by its States parties, and publishes its interpretation of the provisions of the Covenant, known as general comments.

[66] *Gen Comm 14* (2000) which concerns the interpretation of Article 12 of the International Covenant of Economic, Social and Cultural Rights.

[67] See, eg. *Gen Comm 29* (2001); *Gen Comm 31* (2004).

[68] See for example *Keenan -v- GBR* (2001); *Hurtado -v- CHF* (1994); *Pantea -v- ROM* (2003), as well as Lines 2006 and Lines 2008. Also see the extensive discussion of relevant case law in ECHR 2017a and ECHR 2017b. There is no right to health per se in the European Convention, although recent decisions indicate a possible emerging de facto right to health may be found in the scope of other rights within the European Convention. See, for example, the discussion Graham 2017.

[69] The UN Human Rights Committee is the body of independent experts that monitors implementation of the International Covenant on Civil and Political Rights by its States parties. It also publishes its interpretation of the provisions of the Covenant, known as general comments, and fulfils the same role as the Committee on Economic, Social and Cultural Rights (referred to in fn65 above).

[70] *Gen Comm 21* (1993).

- Prisoners enjoy all the rights set forth in the ICCPR, subject to "the restrictions that are unavoidable in a closed environment", that
- Treating all persons deprived of their liberty with humanity and with respect for their dignity is a fundamental and universally applicable rule, and that "consequently, the application of this rule, as a minimum, cannot be dependent on the material resources available in the State party", and
- That Article 10 engages the obligation to provide appropriate medical care to detainees.

The ICCPR was followed by a succession of other UN instruments which have expanded the detail and scope of rules relating to detention conditions, including incorporating the principle of equivalence:

- In 1955 the UN agreed the *Standard Minimum Rules for the Protection of Prisoners*.[71]
- In 1975 the UN *Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* was approved,[72] Article 1 of which stated that torture 'does not include pain or suffering arising only from, inherent in or incidental to, lawful sanctions to the extent consistent with the Standard Minimum Rules for the Treatment of Prisoners'.
- In 1982 the UN General Assembly explicitly adopted[73] the principle of equivalence, stated in the following terms:

  Those charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.
- In 1985 the UN *Standard Minimum Rules for the Administration of Juvenile Justice*, (the Beijing Rules) were adopted for the protection of young offenders.

[71] UN 1955.
[72] Adopted by General Assembly on 9 December 1975: UN 1975a, who also passed a resolution specifically in relation to prisons and torture: UN 1975b.
[73] UN 1982.

- In 1988 the UN General Assembly approved the *Body of Principles for the Protection of All Persons under any form of Detention or Imprisonment*.[74]
- In 1990 the UN approved the *Basic Principles for the Treatment of Prisoners*,[75] which state that prisoners should have access to health services available in the country without discrimination based on their legal status.
- The UN Convention against Torture was adopted in 1984, and it was made clear in General Comment 2 by the Committee Against Torture[76] that the Convention applies in all contexts of custody or control, including prisons. The Optional Protocol to the Convention established the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, which creates an optional process of monitoring of prisons at both national and international levels.
- In 2010 the UN Rules for the *Treatment of Women Prisoners and Non-custodial Measures for Women Offenders* (the Bangkok Rules) were approved.[77]
- In 2015 the Standard Minimum Rules were revised and updated, and were adopted by the UN General Assembly as the Nelson Mandela Rules. Rule 24 of the Mandela Rules states that: *The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.*

The Mandela Rules are not binding, nor intended to describe in detail a model prison system. The Preliminary Observations to the Rules states that they "seek only, on the basis of the general consensus of contemporary thought and the essential elements of the most adequate systems of today, to set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management."[78]

[74] UN 1988.
[75] UN 1990.
[76] *Gen Comm 2* (2008).
[77] UN 2010.
[78] UN 2016d, Preliminary observation 1.

There have also been a number of prison-specific human rights developments at regional level. As mentioned above, the most prominent example of these is within Europe,[79] where the Council of Europe has developed extensive standards and mechanisms:

- Article 3 of the European Convention for the Protection of Human Rights and Fundamental Freedoms[80] prohibits torture and inhuman or degrading treatment or punishment, which mirrors the prohibitions in the UN Convention Against Torture.
- In 1987 the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment were adopted, which also established rules and procedures for prison inspections and created the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) to conduct inspections.
- Also in 1987, the Council of Europe adopted the European Prison Rules, updated in 2006, with extensive provision for health and other treatment, including relevantly:[81]

  40.1 Medical services in prison shall be organised in close relation with the general health administration of the community or nation.

  40.2 Health policy in prisons shall be integrated into, and compatible with, national health policy.

  40.3 Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.

  40.4 Medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer.

  40.5 All necessary medical, surgical and psychiatric services including those available in the community shall be provided to the prisoner for that purpose

[79] Other regional examples include the adoption in 1995 by the African Commission of the Resolution on Prisons in Africa, which extended the rights and protections set forth in the African Charter on Human and Peoples' Rights to prisoners and detainees; and the 2008 Inter-American Commission on Human Rights, 'Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas'.

[80] More generally 'the European Convention on Human Rights'. This was adopted by the Council of Europe in 1950 and entered into force in 1953: ECHR ud.

[81] CoE 2006.

While the principle is embedded within these instruments, the process of interpretation of the principle reveals the difficulties involved in its application. The European Court of Human Rights has held on many occasions that the detention of a person who is ill may raise issues under Article 3 of the European Convention on Human Rights, and that the lack of appropriate medical care may amount to treatment contrary to that provision.[82] However the level and nature of health care required in practice remains a matter for judicial interpretation. In *Gladkiy v Russia,* for example, the Court reviewed its previous case law on this issue and found that it discloses that freedom from inhuman or degrading treatment cannot be interpreted as "securing for every detained person medical assistance at the same level as in the best civilian clinics." The Court stated that its decision making indicates that it reserved "sufficient flexibility in defining the required standard of health care, deciding it on a case-by-case basis", and that the standard should be compatible with the human dignity of a detainee, but also take into account the "practical demands" of imprisonment.[83]

In *Wenner v Germany,* however, the Court found that the standard required was not met, and Article 3 of the European Convention was breached, when Germany failed to provide comprehensive and adequate medical care in detention "at a level comparable to that which the State authorities have committed themselves to provide to persons in freedom, where drug substitution was available."[84]

Rights relating to health and ill-treatment can be seen as mutually reinforcing, whereby promotion and protection of the right to health strengthens the prevention of torture and ill-treatment, and the prohibition of torture reinforces the realisation of the right to health.[85] This position is consistent with the Mandela Rules, which are premised on a framework of human dignity and a recognition that authorities are required to make reasonable accommodation for the needs of prisoners with disabilities. This approach within the Mandela Rules reflects the principles of the CRPD, and is an illustration of the way in which prison health necessarily requires a connection between the notions of the principle of equivalence and of substantive equality.

---

[82] See fn68 above.
[83] *Gladkiy -v- RUS* (2010), [85].
[84] *Wenner -v- DEU* (2016), [80].
[85] This was considered for example by former Special Rapporteurs on Torture and on the Right to Health, Nigel Rodley and Paul Hunt, reviewed in Lines 2008.

3.2 Substantive equality and the CRPD

The CRPD came into force in May 2008, with its purpose framed around the substantive equality of persons with disabilities. As Perlin and Dlugacz have noted[86], it has the strong potential to reframe prison mental health rights and services in line with a disability rights model. The CRPD represents a watershed in the conceptualisation of disability and in expanding the concepts of substantive equality and non-discrimination across a far greater ambit. Lord and Brown note that a core goal of substantive equality is:

> *to ensure the equal distribution of benefits among members of society and to transform the unequal power relations between persons that may inhibit equal access to human rights. In some circumstances, this may require treating persons with disabilities differently, where treating them the same would fail to recognize critical needs, ignore barriers to full inclusion and undermine realization of human rights.*[87]

The social model of disability described in the CRPD obliges governments to enable access for persons with disabilities[88] to services and programmes on an equal basis to non-disabled persons. This reorientation of disability issues as 'rights claims', rather than medical or charitable concerns, shifts the focus of state action to modifying the environment to ensure the person with a disability can enjoy their rights, in contrast to requiring the individual to adjust to pre-determined policies or facilities.[89]

The core of the CRPD is the requirement in Article 5(2) that states parties prohibit all discrimination on the basis of disability, defined in Article 2 to mean:

> *[A]ny distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.*

---

[86] Perlin & Dlugacz 2009, 692-694.
[87] Lord & Brown 2011.
[88] Within the CRPD persons with disabilities includes those who have "long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others": *CRPD* (2006), art 1.
[89] Thakkar 2015; Frawley & Naylor 2014, 63.

Critically, discriminatory impact can be found regardless of intent. As noted by the CRPD Committee in the case of *Noble v Australia*,[90] commenting on the impact of criminal justice processes on a detained man with a mental disability:

> *Discrimination can result from the discriminatory effect of a rule or measure that is not intended to discriminate, but that disproportionately affects persons with disabilities.*

The CRPD obliges states to consider the particular situation of people with disabilities, and to make reasonable accommodations to ensure that people with disabilities can access their rights on an equal basis, with reasonable accommodation defined in Article 2 as:

> *Necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.*

The Mandela Rules were negotiated several years after the CRPD took effect, and reflect the substantial conceptual leap made by the CRPD in relation to the social model of disability. While the Mandela Rules do not use the term 'substantive equality', the construction of the Rules describes a substantive equality approach to the application of rules and policies. This substantive equality approach may be discerned particularly within the basic principles, comprising the first five rules. These include requirements that the rules be applied impartially and without discrimination on various listed grounds (Rule 2), and sets out the following provision regarding how this principle of non-discrimination should be applied:

> *[P]rison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings. Measures to protect and promote the rights of prisoners with special needs are required and shall not be regarded as discriminatory* (Rule 2).

The basic principles also require authorities to ensure that prison system shall not aggravate the inherent suffering inherent in imprisonment, except as incidental to justifiable separation or the maintenance of discipline (Rule 3).

---

[90] *Noble -v- AUS* (2016), p15.

The Rules also require an individualised assessment of the situation of, for example, prisoners with mental disabilities. Authorities are required to offer assistance, including health services, in line with the individual treatment needs of prisoners (Rule 4). Perhaps the clearest alignment with the substantive equality approach of the CRPD is set out in Rule 5, which provides:

> *Prison administrations shall make all reasonable accommodation and adjustments to ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis.*

3.2.1 Applying the CRPD to the prison setting

In the area of criminal justice, the CRPD Committee, the treaty body responsible for the CRPD, has considered some individual cases challenging decisions of prison authorities on the basis that they breached the obligations of the CRPD.[91]

In 2014 the CRPD Committee considered a complaint from a wheelchair-using prisoner, Mr X.[92] Mr X argued that the prison conditions were affecting his physical and mental health and that he could not maintain personal hygiene because he could not get to the bathroom on his own. While the Argentine authorities had made some adjustments, the Committee found that these were inadequate and that the authorities had also breached Article 9 of the CRPD (Accessibility) by failing to ensure that Mr X was able to use prison facilities and health care on an equal basis with other detainees. The Committee found that Argentina was obliged to take action to prevent similar violations, including making sufficient and reasonable adjustments when requested, to ensure persons with disabilities could access prison facilities and health care. The Committee also held that Mr X's detention conditions were incompatible with Article 17 of the CRPD, which states that every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others. The European Court of Human Rights has found

[91] The Committee is established under the CRPD to monitor implementation of the CRPD.
[92] *X -v- ARG* (2014).

that similar complaints by prisoners in wheelchairs have breached Article 3 of the European Convention on Human Rights.[93]

A more directly relevant case for people with mental disabilities is the 2016 case of *Noble v Australia,*[94] where the Committee found that Australia had violated the rights of a man with an intellectual disability, Mr Noble, who was deemed unfit to stand trial but was nevertheless detained in prison for thirteen years. Western Australia's *Criminal Law (Mentally Impaired Accused) Act 1996* provides that a person charged with an offence but found unfit to plead can be held in custody for an unlimited period. The legislation provided Mr Noble no possibility to go before the courts to contest the charges against him until he was deemed able to understand the notion of criminal responsibility. The Committee found that this breached the CRPD and had effectively converted Mr Noble's disability into the core cause of his detention.

The Committee did recognise that States parties have "a certain margin of appreciation to determine the procedural arrangements to enable persons with disabilities to exercise their legal capacity", however the relevant rights of the person concerned must be respected, which it found did not happen in Mr Noble's case. The Committee also considered that the indefinite detention to which Mr Noble was subjected amounted to inhuman and degrading treatment in view of "the irreparable psychological effects that indefinite detention may have on the detained person," and that Australia had failed to fulfil its CRPD obligations.[95]

Both the Mandela Rules and the decisions of the CRPD Committee suggest an evolution is underway in how prison rules and policies should be considered and challenged, particularly for their impact on people with disabilities. It seems likely that these rules and

[93] In the *Case of Semikhvostov v. Russia* a breach of Article 3 was found in relation to a prisoner paralysed from the waist down and confined to a wheelchair who could not access toilets without help from other prisoners, needed assistance to use the bathhouse; could not take exercise outside and had his wheelchair taken away for security reasons: *Semikhvostov -v- RUS* (2014). In *DG v Poland* the Court found that keeping the applicant detained in conditions which were not suitable for persons with physical disabilities and not making sufficient efforts to reasonably accommodate his special needs in the circumstances reached the threshold of severity required under Article 3: *D.G. -v- POL* (2013).

[94] *Noble -v- AUS* (2016).

[95] Under articles 5 (1) and (2), 12 (2) and (3), 13 (1), 14 (1) (b) and 15 of the Convention: see *Noble -v- AUS* (2016), [8.9].

policies will be increasingly subjected to analysis based on concepts of substantive equality and non-discrimination as developed through the CRPD and similar provisions.

3.2.2 Mental capacity and the contested scope of the CRPD

Any consideration of the application of the CRPD within mental health settings must take into account the fact that the scope of the CRPD is contested within international scholarship. Relevantly this debate relates to the interpretation of provisions relating to legal capacity, specifically in relation to consent to treatment by persons whose decision-making capacity is in doubt.

The CRPD provides in Article 12 that "States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life." The CRPD Committee, in its General Comment No. 1 in 2014, considered the interaction of this with Article 25, the right to health, and found that:

> *The right to enjoyment of the highest attainable standard of health (art. 25) includes the right to health care on the basis of free and informed consent. States parties have an obligation to require all health and medical professionals (including psychiatric professionals) to obtain the free and informed consent of persons with disabilities prior to any treatment. In conjunction with the right to legal capacity on an equal basis with others, States parties have an obligation not to permit substitute decision-makers to provide consent on behalf of persons with disabilities.*[96]

Under this construction the CRPD concluded that treatment could in no circumstances be provided involuntarily. This interpretation has been expressly rejected by a number of countries, both in specific reservations to the CRPD and in country reports.[97] It has been the subject of considerable international criticism, including that it may itself violate human rights:

> *"[T]here are times when informed consent is not possible because of the condition of the person and must be superseded, particularly where life is at risk... In our view, excluding any exemption to the*

[96] *Gen Comm 1* (2014), p10.

[97] Many states have entered reservations to the CRPD in relation to Article 12. See the full text of reservations at: UN 2017. Also see, for instance, domestic understandings and applications in the country reports of Australia (AUS Gov 2012, [76] & [96]); Sweden (SWE Gov 2012, [137] & [140]); and New Zealand (NZL Gov 2013, [67]–[69] & [83]–[89]).

> *presumption of legal capacity due to mental impairment, and as a result not allowing a person with severe mental illness or other impairment to have their circumstance treated as exceptional, might in fact violate his or her rights, and in some circumstances could result in harm to self or to others."*[98]

The consequences may extend to criminal justice involvement. Freeman et al,[99] and Dawson[100] argue that the Committee's view implies removing the option of diverting people from prison into mental health treatment, which is likely to be contrary to their rights to justice:

> *"Further problems arise if a person with mental illness is jailed rather than diverted to mental health treatment. First, treatment in prison, even if the prisoner accepted such treatment, is likely to be less effective than treatment in a hospital setting because of differences in staff expertise and environment. Second, the person might be a victim of violence due to stigma and discrimination against persons with mental disorders, and third, should the prisoner be "disruptive", the prison authorities would have little power to provide medical assistance unless consent were given. In view of the circumstances in most prisons, psychotic behaviour might bring serious consequences—if not from the prison authorities, then from other inmates. Thus, convicting a person who committed a crime as a result of serious mental illness and sentencing them to prison rather than diverting them for treatment and possible quick discharge is unlikely to be to their benefit."*[101]

This issue is raised directly in the adaptation of the QualityRights tool for the prison environment. While this is discussed further in Chapter five, this thesis proceeds on the basis that the criticisms of the CRPD Committee's position are compelling. Adopting the Committee's approach raises many other human rights issues and does not indicate how they might be resolved. The Committee's position also faces a pragmatic obstacle in the fact that state parties have indicated that they do not intend to follow this interpretation.[102]

---

[98] Freeman & o'rs 2015, 845.
[99] Freeman & o'rs 2015, 847.
[100] Dawson 2015.
[101] Freeman & o'rs 2015, 847.
[102] Dawson 2015.

3.3 Conclusion

The principle of equivalence is well entrenched within international human rights law, despite the fact that there is little consensus about its application and the precise obligations that flow from it. Decisions by courts illustrate the difficulties of applying the principle, and also a clear function of the principle in demonstrating when prison health services are clearly inadequate, which can also comprise inhuman or degrading treatment.

It seems from this that principle of equivalence can best assist to indicate what prison health services should not be like (below a minimum standard), but in the absence of more sophisticated concepts, it does not provide clarity about what prison health services *should* be like. The limitations of the principle, and, by extension, of a common tool across both prison and non-prison settings, lie in the sheer conceptual and practical difficulties of creating common benchmarks across settings. However the suggestions for moving beyond the principle discussed in Chapter two currently lack a clear framework for maintaining compliance with human rights principles of universality and non-discrimination.

The CRPD provides the opportunity and the obligation to bring into this discussion the legal notions of substantive equality. The CRPD is both directly relevant to prisoners with mental disabilities, and provides a useful model for thinking more multi-dimensionally about equality across settings. Its impact in the prison mental health setting is already being witnessed through the incorporation of its principles into the Mandela Rules, and through consideration of complaints from prisoners by the CRPD Committee. While some aspects of the CRPD's interpretation to mental health remain contested, it appears undeniable that its influence over the sector will be very significant, and that it offers a way of advancing and deepening understandings of the principle of equivalence.

Chapter 4: Adapting the QualityRights tool – Themes 1-2

The QualityRights tool is specifically targeted at assessing the impact of services and facilities on the rights of a particular group of individuals - those with mental disability in a mental health facility – defined as 'any place where people with mental disabilities live or receive care, treatment and/or rehabilitation'.[103] The literature indicates that applications of the tool to date have taken place in psychiatric hospitals and community mental health services.[104]

This chapter considers how the context of prison mental health services varies from mental health services in other settings, the implications of these differences for the adaptation of the QualityRights tool, and proposes suggested adaptations for Themes 1-2. Chapter five continues the discussion in relation to Themes 3-5.

Not every difference between settings will require a change to the tool, and in fact there are distinct advantages to a minimal change model, as this allows maximum comparability with non-prison services. To have value, however, the tool must be capable of identifying discrimination as actually experienced in the setting in which it is applied, as to do otherwise would not give effect to the purpose of the CRPD.

There are similarities and differences between psychiatric hospitals and prison mental health services. As Stevens[105] notes, they share some common features of organisational culture:

1. Both are primarily concerned with the management of people (staff and detained persons) and the relationships between them.
2. The relationship between these two groups is unequal, with staff being in a position of power, and detained persons depending on the authorities for their basic needs as well as for the protection of their rights.

[103] Under Article 1 of the CRPD 'People with mental disabilities' includes those with mental, neurological or intellectual impairments and those with substance use disorders.
[104] See Pelletier & o'rs 2013; Nomidou 2013; Minelotti & o'rs 2015; CAMH 2014.
[105] Stevens 2014.

3. Both are closed environments with limited external checks and balances, which results in them often developing their own cultural norms, into which staff are socialised.

4. The management of such closed environments tends to be by hierarchical and bureaucratic organisations with clear organisational structures and chains of command.

Some of the key differences are mentioned here, with further discussion below in relation to each of the QualityRights tool themes.

An obvious but important difference between psychiatric hospitals and prisons is the expressed rationale for each institution. A mental health inpatient service is a health facility designed to provide treatment and care specifically for people with mental disabilities, and a prison is a correctional facility designed to securely hold people accused of and found guilty of criminal behaviour, and which provides (or should provide) health services as part of its duty of care.[106]

Flowing from this is the fact that all residents of psychiatric hospitals have a shared status as mental health consumers. The QualityRights tool is primarily designed for such settings, where people with mental disorders make up the entire residential population of a facility, and where differential treatment between classes of residents is not therefore a primary driver of discrimination. The situation is different in the case of prisoners with mental disorders, who reside within a more disparate population. In this setting there is a real prospect that prison processes may discriminate against them, whether directly or indirectly, when compared to other prisoners.

There is a second element of discrimination peculiar to prisons, arising from the tendency for prison health services to be administered and funded separately, and at a lower level, than non-prison health services. The consequence can be that people with mental

[106] The cultural differences between the institutions may reflect, or generate, differing prevailing models of disability. In psychiatric hospitals a medical model of disability would seem to be more likely to prevail, under which disability may be seen through the lens of a need for medical intervention to address deficit. In prisons, however, with the overriding focus on security, disability may be more likely to be seen through a lens of risk, viewed in terms of the level of threat posed to the law and order needs of the prison. The CRPD presents a challenge to both of these models of disability.

disabilities in a prison environment have less access to mental health services than people with mental disabilities in non-prison settings. The adapted tool should be capable of identifying both of these elements of discrimination.

These matters are considered in more detail below, with suggested adaptations to the standards within each of the QualityRights tool themes, designed to identify, monitor and address potential areas of discrimination as highlighted in the literature.

In adapting the QualityRights tool, it is important to consider the duties under the CRPD to both provide accessibility[107] and to make reasonable accommodation. Accessibility is a duty on states parties to plan for the removal of barriers affecting disabled people as a group, and reasonable accommodation is a duty owed to a specific individual to make an appropriate adjustment necessary to remove a particular disadvantage or obstacle.[108] As Lawson notes, 'the more accessible an environment or organisation is, the less likely it is that aspects of its structure or functioning will place a disabled person at a disadvantage which calls for reasonable accommodation'.[109] The adapted QualityRights tool needs to encompass both aspects in considering how potentially discriminatory measures can best be addressed.

The following approach will be taken to the adaptation:

1. For each of the five themes within the QualityRights tool, identify from the literature aspects of the prison context which have the potential for significant discriminatory impacts on prisoners with mental disabilities, whether:
    - Because they are disproportionately subjected to the measure in question by reason of their disability, or
    - Because they are disproportionately impacted by the measure in question by reason of their disability.
2. Adapt the tool to identify, monitoring and respond to the above issues, taking account of potential discrimination against prisoners with mental disabilities:

[107] Accessibility is a general principle of the CRPD and also an obligation detailed in Article 9 and set out in Articles 4 and 21. Accessibility obligations apply to physical infrastructure, information and signage as well as to information and communication technologies and transport.
[108] Lawson 2012, 850.
[109] Lawson 2012, 850.

- when compared to prisoners without mental disabilities, and
- when compared to non-prisoners with mental disabilities.

3. The adaptation is intended to:
   - reflect the purpose of the CRPD, and
   - draw on the Mandela Rules, which reflect the international consensus as to standards for prison conditions.

4.1 Theme 1: An adequate standard of living

Standards under the current QualityRights tool

Standard 1.1 The building is in good physical condition.

Standard 1.2 The sleeping conditions of service users are comfortable and allow sufficient privacy.

Standard 1.3 The facility meets hygiene and sanitary requirements.

Standard 1.4 Service users are given food, safe drinking-water and clothing that meet their needs and preferences.

Standard 1.5 Service users can communicate freely, and their right to privacy is respected.

Standard 1.6 The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.

Standard 1.7 Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities

4.1.1 Standards 1.1-1.4 - commentary

Theme 1 of the QualityRights tool is referenced against Article 28 of the CRPD,[110] the two paragraphs of which recognise the rights of persons with disabilities to an adequate standard of living without discrimination and to social protection without discrimination.

[110] This and the other reference articles of the QualityRights tool are reproduced in the Appendix.

Living conditions are an important issue to prisoners as a whole and to prisoners with mental disabilities as a specific group. Overall numbers and rates of imprisonment have increased globally in recent decades,[111] and the poor living conditions which accompany overcrowding - inadequate sanitary facilities, poor hygiene, poor nutrition, and inadequate access to drinking water - facilitate ill health.[112] There is evidence that such conditions have a disproportionate impact on prisoners with mental disorders.[113]

Noting that standards exist for prisoners' living conditions,[114] the focus for this theme of the adapted QualityRights tool should be potential discrimination in relation to living conditions. This issue is addressed in the Mandela Rules. In addition to the Basic Principles of the Mandela Rules, which include the principle of non-discrimination generally, a specific requirement for non-discrimination in the matter of living conditions is set out in Rule 42:

> *General living conditions addressed in these rules, including those related to light, ventilation, temperature, sanitation, nutrition, drinking water, access to open air and physical exercise, personal hygiene, health care and adequate personal space, shall apply to all prisoners without exception.*

In light of the above discussion, the adapted tool should reflect the following identified issues:

- Recognise that living conditions within prisons can have a disproportionate impact on prisoners with mental disabilities, and monitor this impact;
- Identify discrimination against prisoners with mental disabilities in relation to living standards; and
- Ensure that there is a process for consideration in relation to living conditions of reasonable accommodation on an individualised basis.

Proposed new standards for this theme are listed below. Issues in relation to isolation and restricted housing are discussed within Theme 3, in the context of freedom from arbitrary deprivation of liberty.

---

[111] Coyle & o'rs 2016, 37.
[112] Coyle & o'rs 2016, 77-90; Sander & Lines 2016, 177-178.
[113] Sander & Lines 2016, 177-8; Durcan & Zwemstra 2014.
[114] A number of the Mandela Rules deal specifically with requirements for living conditions of prisoners, in particular Rules 12-17 (Accommodation), Rule 18 (Hygiene), Rules 19-21 (Clothing and bedding) and Rule 22 (Food).

4.1.2 Standards 1.5-1.7 - commentary

Standards 1.5-1.6 of the QualityRights tool do not have the clear nexus with Article 28 that the preceding standards do, whether in respect of living standards or social protection. These standards are also less clearly applicable in a prison setting, where security imperatives make it unrealistic to expect unrestricted communication and privacy, for example. Assessing prison environments against a standard of being 'welcoming' is similarly less meaningful in the prison setting, given the role of prisons. Accordingly alternative standards are proposed in the adapted tool, focusing on the second limb of Article 28, social protection - initiatives to protect against livelihood risks and reduce the economic and social vulnerability of poor and marginalised groups.[115]

An important social protection measure is equality of access to health coverage, also addressed within Article 25, which relevantly requires states to:

- Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes; and
- Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner.

State-provided health insurance and social protection schemes have considerable potential to assist socially vulnerable populations such as prisoners.[116] Social protection and health coverage is of particular importance to prisoners with mental disabilities, and its absence has been directly linked to the fact that the death rate for released prisoners is several times higher than for others of similar age, race, and sex.[117] Australia and the United States provide striking examples of this exclusion.

[115] Devereux & Sabates-Wheeler 2004.
[116] WHO 2012b.
[117] Schlanger 2017, 28

In the United States Medicaid, the means-tested, federally funded social protection program, was expanded, subject to individual opt-in by state administrations, pursuant to the *Affordable Care Act*. Within those states electing to accept the expansion, nearly every incarcerated person would meet the eligibility criteria for the Medicaid program, meaning that federal funds would pay for their prescribed health care services.[118] However a federal policy, the Medicaid Inmate Payment Exclusion policy, limits or prohibits Medicaid payments for health care services for incarcerated persons, with the effect that these services are in many cases unavailable to this class of people.[119] Incarceration rates in the U.S. have increased 650% since the commencement of Medicaid in 1965, vastly expanding the scale and public health impact of this exclusion from Medicaid.[120]

In Australia prisoners are similarly excluded by legislation from the federally-funded public health insurance scheme, Medicare.[121] There is evidence that as a result, prisoners do not receive certain services and medications considered by state governments to be too expensive to provide without Medicare funding.[122]

The Mandela Rules are not explicit about the inclusion of prisoners in social protection schemes, beyond the requirement in Rule 24.1 that:

> *The provision of health care for prisoners is a State responsibility. Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.*

Given the importance of health coverage to people with disabilities, and the overrepresentation of this group within the incarcerated population, the exclusion of

[118] Winkelman & o'rs 2017.
[119] US Gov 2016.
[120] Winkelman & o'rs 2017.
[121] By virtue of the *Health Insurance Act*, prisoners are excluded from Medicare and from the subsidisation of priority medicines, the Pharmaceutical Benefits Scheme (PBS) (other than PBS Schedule 100, the Highly Specialised Drugs Program), on the basis that equivalent services are provided by State and Territory governments: *Health Insurance Act 1973* (AUS). Section 19(2) of the Act provides that where health services are being provided by, on behalf of, or under an arrangement with any government entity (whether federal, state or territory), Medicare will not be available unless the Minister for Health or his/her delegate grants an exemption to this exclusion. As state-funded entities, prisons fall under this provision. The legislation operates to exclude prisoners from Medicare because the state or territory in which they are incarcerated is assumed to provide equivalent services, as described by Plueckhahn & o'rs 2015.
[122] Plueckhahn & o'rs 2015.

prisoners from national health insurance and social protection schemes arguably operates as indirect discrimination against people with mental disabilities.

Standard 1.7 relates to social interaction, activities and community engagement, matters which are addressed directly in Theme 5 in relation to Article 19.

4.1.3 Proposed new standards for Theme 1

Standard 1.1a Prison policies and practices recognise that living conditions within prisons can have a disproportionate impact on prisoners with mental disabilities.

Standard 1.2a Processes exist to identify whether there are any substantive differences between the living conditions of prisoners with mental disabilities and those without.

Standard 1.3a Effective processes are in place to ensure appropriate consideration is given, on an individualised basis, to reasonable accommodation requests by prisoners with mental disabilities in relation to living conditions, and prisoners are supported to make these requests.

Standard 1.4a Prisoners with mental disabilities face no discrimination on the basis of their justice involvement to accessing social protection and public health coverage schemes.

Standard 1.5a Prison authorities actively connect prisoners with mental disabilities into social protection and public health coverage schemes.

4.2 Theme 2: Enjoyment of the highest attainable standards of physical and mental health

Theme 2 draws upon Article 25 of the CRPD, dealing with the right to health.

Standards under the current QualityRights tool

Standard 2.1 Facilities are available to everyone who requires treatment and support.

Standard 2.2 The facility has skilled staff and provides good-quality mental health services.

Standard 2.3 Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community.

Standard 2.4 Psychotropic medication is available, affordable and used appropriately.

Standard 2.5 Adequate services are available for general and reproductive health.

4.2.1 Standards 2.1-2.5 - commentary

The standards within this theme focus on the availability, accessibility, appropriateness and quality of health services for people with mental disabilities. Both the demand side and the supply side of prison mental health services are affected by factors unique to the prison context, with strong potential to limit the services for prisoners with mental disabilities. Of note are the particular demographics within the prison population, and the relatively limited power of prison mental health services within larger correctional and health systems.

5.1.1.1 The impact of prison demographics on prison mental health services

The distinct demographics of the incarcerated population create a specific set of pressures for prison health services. Firstly, as discussed in Chapter one, the health needs of prison populations are greater and more complex than in the general community. Epidemiological studies consistently demonstrate that the prison population overwhelmingly consists of marginalised and vulnerable populations, typically with a lifetime of social exclusion and associated high levels of complex health needs.[123] Incarcerated people have a disproportionate burden of mental illness,[124] chronic physical disorders[125] and communicable diseases, and much higher rates of risky alcohol consumption, tobacco smoking and illicit drug use.[126] The health of prisoners is sufficiently poorer than the general community in Australia, for example, that prisoners are often considered to be geriatric at the age of 50–55.[127]

[123] Woodall & o'rs 2014. There is evidence that prison health services may in some cases also experience an expressed demand for care by the population which is considerably greater than that of the general population. A UK study found, for example that prisoners consult, on average, three times more often for general care than a demographically equivalent population in the community: Howerton & o'rs 2007.
[124] Woodall & o'rs 2014 p5; Durcan & Zwemstra 2014.
[125] Woodall & o'rs 2014.
[126] Woodall & o'rs 2014; Baybutt & o'rs 2014.
[127] AUS Gov 2015.

Secondly the prevalence of mental illness is higher and differently experienced amongst specific non-mainstream populations in prison, in particular women and Indigenous people, both discussed further below. This implies that prisons and prison mental health services will have an appropriate range of responses for these groups. However, as Coyle et al note, the traditional tendency of prisons is to adopt standardised approaches, with policy and practice tending to be shaped "as if all prisoners were adult men from the main ethnic, cultural and religious groupings in the country."[128]

Women make up on average 9-11% of prison populations, meaning prisons tend to be organised on the basis of the needs and requirements of male prisoners.[129] However the evidence indicates that female prisoners' experience of mental health problems is very different to that of male prisoners. The WHO Health in Prisons Program summarises the research,[130] including that:

- Women in prison are more likely to have mental health problems than both the general population and male prisoners, including high rates of post-traumatic stress disorders.[131]
- Women's mental health is particularly likely to deteriorate in prisons that are overcrowded, where prisoners are not properly differentiated and where programmes are either non-existent or inadequate to address the specific needs of women.[132]
- Rates of sexual victimization in prison for prisoners with and without mental disorders have been found to be approximately 2.5 times higher for those with a mental disorder and three times higher among female prisoners compared to males. Thus the combination of being female and having a mental disorder is associated with a very high likelihood of harm.[133]

[128] Coyle & o'rs 2016, 96.
[129] Coyle & o'rs 2016, 99.
[130] Coyle 2014, 6-7 and van den Bergh & o'rs 2014.
[131] Bastick & Townhead 2008; and Moloney & o'rs 2009 cited in Coyle 2014, 6-7.
[132] Coyle 2014, 6-7 and van den Bergh & o'rs 2014.
[133] Wolff & o'rs 2007 cited in Modvig 2014, 22.

Article 25 of the CRPD relevantly obliges states to "take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation."

Indigenous people are over-represented in prisons globally, and massively so in particular countries.[134] The defining feature of Australian prisons, for example, is the very high over-representation of Aboriginal people.[135] Indigenous people across Australia have an age-adjusted imprisonment rate which is 13 times the rate of imprisonment for non-Indigenous people, and the rate is far higher than this in particular states and territories.[136] Those in custody have relatively high rates of health problems including poor mental health, much higher levels of trauma and co-occurring conditions, combined with a high degree of historic non-engagement with and distrust of services.[137]

There is increasing awareness that the way Indigenous people conceive of and experience mental health and the prison environment is generally very different to mainstream populations.[138] A lack of culturally appropriate services and culturally informed staff has the effect of limiting access, acceptability and effectiveness of services for Indigenous people.[139]

The Mandela Rules contains little on the specifics of gender-sensitive and culturally secure services in prisons. However the approach set out within the Basic Principles of the Rules would appear to require prison authorities to consider these factors in developing treatment plans and programs for prisoners. In particular, as noted in Chapter three, Rule 4 requires prison authorities to offer assistance, including health services, in line with the individual treatment needs of prisoners. Considerable work has been done in this area which could be drawn upon by prison authorities. Specific guidance relating to female prisoners is set

[134] Coyle & o'rs 2016, 97.
[135] In Western Australia, for example, Aboriginal people are imprisoned at a significantly higher rate than other Australians. While 40% of adult prisoners and three quarters of young detainees are Aboriginal, Aboriginal people comprise only 2.9% of the state's population: AUS Gov 2015.
[136] AUS Gov 2016b.
[137] Heffernan 2016.
[138] Vicary & Westerman 2004.
[139] Heffernan 2016.

out the UN Bangkok Rules,[140] and principles relating to cultural security of prisons has been developed by different bodies, notably in Australia.[141]

There seems little doubt as to the identified higher prevalence and specific needs in relation to services. A failure by authorities to consider the accessibility of these services, and reasonable accommodations to them for Indigenous people and female prisoners could breach CRPD obligations and also the International Convention on the Elimination of Racial Discrimination and the Convention on the Elimination of all forms of Discrimination Against Women.[142]

5.1.1.2 The isolation of prison health and mental health services within larger systems

Prison mental health services typically operate within larger general prison health services, which are themselves a small part of a much larger correctional institution. Prison health services themselves often operate in separate administrative and functional spheres to the general health system. Several aspects of this arrangement have significant and potentially discriminatory impacts on the quality and availability of health services for prisoners with mental disabilities, as discussed below.

Within the prison system

An important difference between prisons and psychiatric hospitals for the purposes of the QualityRights tool is that, unlike administrators of psychiatric hospitals, prison health administrators typically exercise little or no control over such fundamental matters as how and why people enter the institution, the basic conditions in which people live, and the processes and procedures which govern their accommodation and daily lives.

A defining feature of life within prison is the fluidity of the prison population. Prison processes are characterised by many transitions which are not mirrored in the community, related to the use of movement to manage security needs and overcrowding, and to

[140] UN 2010.
[141] Examples from the Australian context are AUS Gov 2016a (endorsed by all state and territory governments and the national government); also WA Gov 2008.
[142] Thornberry 2016, 375-378; *Gen Comm 33* (2015).

prisoners constantly entering and being released from prison.[143] There are many ways in which this particularly impacts on prisoners with mental disorders. Delays in being able to establish communication with a prisoner's community-based general practitioner or psychiatrist, or to confirm existing prescriptions, create disruptions to regular medications or changes to established medication practices.[144] Such issues may leave prisoners at increased risk of mental instability at the particularly difficult time of transition into prison. The uncertainty surrounding release dates for remand prisoners, determined by legal applications and decisions of courts and police, increases the difficulties associated with continuity of care in the community following release.[145]

Within the broader health system

In addition to being exempted from national health insurance schemes, prison and forensic mental health systems can also be subject to very different features and drivers of admissions, length of stay and costs of providing care. Often these matters are determined by specific criminal justice legislation in force in a jurisdiction.[146] One consequence in Australia is that the funding of inpatient forensic mental health services is considered too distinct from non-forensic services to be funded on the same basis.[147]

[143] A snapshot of Australia's prisoners on 30 June 2014, for example, showed that a quarter of prisoners were on remand while awaiting trial or sentencing, and for sentenced prisoners, the median time expected to serve was 1.8 years: AUS Gov 2015.

[144] Borschmann & o'rs 2016; Wilson 2004; Bowen & o'rs 2009.

[145] Schwitters 2016.

[146] By way of example, in Western Australia the *Criminal Law (Mentally Impaired Accused) Act* establishes processes for court-mandated mental health admissions, reviews and releases which are at often at odds with clinical priorities for the provision of care. For example, the State has one facility for inpatient treatment which meets the security needs for prisons requiring inpatient mental health treatment. However this facility is also obliged to admit all referrals made to it directly from the courts, which can be made without advance warning to the facility. Beds are limited, and the inevitable result is that prisoners in hospital are required to be returned to prison at short notice, despite the fact that:

- under normal circumstances they would be not be considered well enough to be discharged from hospital and may be mid-treatment, and
- frequently these prisoners are more unwell than the court referral patients they are being discharged to make room for: see *Criminal Law (Mentally Impaired Accused) Act* (AUS).

[147] Most inpatient services in Australia are funded on an Activity Based Funding (**ABF**) model, applied nationally The National Health Reform Agreement, signed by the Commonwealth Government and all states and territories in August 2011, commits to funding public hospitals using Activity Based Funding (ABF) where practicable: COAG 2011. The ABF model funds hospitals for the number and mix of patients they treat, taking into account that some patients are more complicated to treat than others. Forensic inpatient services, however, are funded on a block or per diem basis. As the ABF model is premised on the basis that health services have full control over the decisions to admit and discharge, the severing of the nexus between health services and patient flow means the ABF model has to date been considered unable to be applied to forensic services.

The different resourcing context of prisons can require decisions by mental health administrators which have implications for availability of services. The basis on which the inevitable rationing of care to prisoners should take place will often, for example, be less clear than in a health institution.[148] Consequences include prison doctors finding it difficult to justify prescribing expensive treatments that are readily available in the wider community, and a limited range of treatments being available because of inadequate resources to administer or monitor certain treatments in prison.[149.]

A further structural difference highlighted in the literature is that in some jurisdictions specialist services do not accept prisoners on the same basis as other patients.[150] Wilson and Birmingham et al suggest that this reflects an underlying assumption that prisoners can safely be kept and treated in prison. It may also reflect concerns regarding security, and unspoken questions as to whether resources would be better directed towards other patients. Whatever the motivation, the result is to impose different requirements and expectations on prison health services than general health services, and to limit access by prisoners to specialist services.[151]

4.2.2 Proposed new standards for Theme 2

In light of the above discussion the following adapted standards are proposed for Theme 2:

Standard 2.1a Mental health services are organized in a way that ensures continuity of treatment and care. Adaptations and reasonable accommodations to prison operational management, including transfers and lockdowns, are appropriately considered in order to minimise disruptions to the health services.

Standard 2.2a Mental health services are gender sensitive and recognise the specific needs of women prisoners.

[148] Hunt & Mesquita 2006; Birmingham & o'rs 2006.
[149] Niveau 2007.
[150] Birmingham & o'rs 2006; Wilson 2004.
[151] Salize & o'rs 2007.

Standard 2.3a Prison mental health services are culturally secure and recognise the specific needs and beliefs of prisoners from non-dominant cultural groups.

Standard 2.4a Specialist health services are available to and accessed by incarcerated people with mental disabilities with no discrimination as to eligibility compared to non-incarcerated people with mental disabilities.

Standard 2.5a The relative budget for mental health resources and staff within the prison health service is comparable to level in the community services, if assessed on the basis of clinical need.

Standard 2.6a The availability, affordability and methods of use of psychotropic medication is equivalent inside the prison as outside the prison.

Chapter 5: Adapting the QualityRights tool – Themes 3-5

This chapter continues the analysis of each theme within the QualityRights tool, and proposes adapted standards for themes 3-5.

5.1 Theme 3: Legal capacity, personal liberty and security of person

Standards under the current QualityRights tool

Standard 3.1 Service users' preferences regarding the place and form of treatment are always a priority.

Standard 3.2 Procedures and safeguards are in place to prevent detention and treatment without free and informed consent.

Standard 3.3 Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity.

Standard 3.4 Service users have the right to confidentiality and access to their personal health information.

5.1.1 Standards 3.1 – 3.4 - commentary

This theme is referenced to Articles 12 and 14 of the CRPD, covering areas of consent and capacity as well as liberty and security of the person.

5.1.1.1 Consent

Several factors about the prison setting complicate the concept of consent. Firstly the institutional environment is inherently coercive, with some analyses arguing that consent may rarely be able to be considered entirely voluntary.[152] Secondly, the resourcing and structuring of prison health services means that there is frequently limited or no choice as to fundamental matters such as doctor, place of treatment and the nature of treatment. In the absence of alternative choices, consent becomes a reduced concept.[153]

[152] See for example Birmingham & o'rs 2006, who note that it is often argued that valid consent is almost impossible in prison given the environmental influences

[153] Niveau 2007, 611.

A further issue complicating consent is the capacity for the perceived or actual blurring of the roles of health staff employed in prison settings. The presence of a doctor in a prison restraint situation, for example, can arguably legitimise restrictive practices which in a health facility would be prohibited or regulated by health regulations. The issue of dual loyalties for health staff also arises in relation to requests for medical clearances for the infliction of punishments, monitoring of prisoners in solitary confinement, and in hunger strikes and force feeding.[154]

These issues have been addressed in a number of declarations as to the ethical obligations of medical practitioners working in prison settings,[155] and WHO HIPP has emphasised the necessity for all prison health staff to "remember that their first duty to any prisoner who is their patient is clinical."[156] These issues are also reflected in Rule 32 of the Mandela Rules, which provides a useful model for adapting the QualityRights tool:

1. *The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community, in particular:*
    a) *The duty of protecting prisoners' physical and mental health and the prevention and treatment of disease on the basis of clinical grounds only;*
    b) *Adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship;*
    c) *The confidentiality of medical information, unless maintaining such confidentiality would result in a real and imminent threat to the patient or to others;*
    d) *An absolute prohibition on engaging, actively or passively, in acts that may constitute torture or other cruel, inhuman or degrading treatment or punishment, including medical or scientific*

[154] See 'Dual loyalties of health care staff' in APT ud-b.
[155] See, for example:
- *Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians for the Protection of Detained Persons and Prisoners Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*: UN 1982;
- *Guidelines for Physicians Concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*: WMA 1975;
- *Declaration on Hunger Strikers*: WMA 1991;
- *Statement on Body Searches of Prisoners*: WMA 1993;
- *Declaration Concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading treatment*: WMA 1997; and
- *Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of Which They Are Aware*: WMA 2003.

[156] Coyle 2014, 6-7.

experimentation that may be detrimental to a prisoner's health, such as the removal of a prisoner's cells, body tissues or organs.

2. *Without prejudice to paragraph 1 (d) of this rule, prisoners may be allowed, upon their free and informed consent and in accordance with applicable law, to participate in clinical trials and other health research accessible in the community if these are expected to produce a direct and significant benefit to their health, and to donate cells, body tissues or organs to a relative.*

A further issue for this theme is how involuntary treatment, including through referral to a specialist mental health service, should be dealt with. The phrasing of standard 3.2, which requires that all treatment be subject to consent, reflects the position of the Committee on the CRPD as to involuntary treatment, discussed in Chapter three. As also discussed, however, this position faces both conceptual and practical difficulties in application and is unlikely to be accepted by States Parties. This issue is contested, however the prison setting makes the position of the Committee on the CRPD, if anything, more difficult to apply.

In jurisdictions where involuntary treatment under mental health legislation is permitted only in authorised hospitals, not in prisons[157], the interpretation of the CRPD Committee can result in acutely ill people spending lengthy periods in non-therapeutic settings without treatment, with further entrenchment in the criminal justice system. At a purely pragmatic level, it also seems likely that a prohibition on involuntary treatment would result in a lowered threshold for 'consent' in the prison setting. The pressures and uncomfortable choices facing prison clinicians in interpreting consent and necessity because of limitations in access to hospital and involuntary treatment indicate that such matters are highly sensitive to context and are highly ethically contentious.[158] There are also distinct difficulties in the practical targeting of mental health care and resources in prison settings in a way that consistently and rationally matches need.[159] Similarly, Wilson discusses dilemmas for mental health staff in responding to lengthy delays in assessment and transfer of unwell prisoners to hospital. He describes prison psychiatrists electing not to treat

[157] For example Australia, England and Wales.
[158] Wilson 2004, 5.
[159] For more detailed discussion of this see Forrester & o'rs 2013.

patients, because to do so may result in them missing out on much-needed opportunities for hospital treatment, as they would have risen above the threshold for admission.[160]

Some of these matters are inevitably context-specific, and also not easily the subject of generalised standards. However some issues can be distilled. The proposed standards should recognise that additional safeguards are required to ensure consent by prisoners with mental disabilities to any aspect of treatment is freely given. They should also recognise the importance of health staff routinely acting in a way which demonstrates their clinical independence, including in relation to matters of consent of prisoners with mental disabilities.

5.1.1.2 Deprivation of liberty

Article 14 of the CRPD relevantly provides that states shall "ensure that persons with disabilities, on an equal basis with others...are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty." The Article further specifically refers to the guarantees in such cases of treatment in compliance with the CRPD, including by provision of reasonable accommodation.

Whilst all prisoners are deprived their liberty, there is also the capacity for further restrictions to be placed on prisoners within the prison setting, and the capacity for these measures to operate in a discriminatory manner. Specifically the use of seclusion, isolation and restricted housing is a very significant issue for prisoners with mental disabilities.

People with mental disabilities are grossly overrepresented in isolation units, and are particularly vulnerable to its impacts.[161] WHO HIPP describe the body of evidence indicating that individuals with pre-existing mental illness have a very high risk of worsening psychiatric problems as a result of their isolation.[162] The very damaging effects that solitary confinement has on people with mental illness have also been recognized by the American Psychiatric Association, which stated in 2013 that: "Prolonged segregation of adult inmates

[160] Wilson 2004.
[161] Fazel & o'rs 2011, cited Shalev 2014, 29.
[162] Grassian 2006; Haney 2003; Kupers & Toch 1999; Reid 2000 and *Renolde -v- FRA* (2008), all cited in Shalev 2014, 29.

with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates".[163]

Prisoners with mental disabilities may be segregated for different reasons - for their own protection because they are victimized by other prisoners, because they misunderstand the rules and regulations that govern prison life,[164] or simply as an automatic classification decision.[165] Placements of mentally disabled prisoners administrative segregated housing, isolation within an infirmary, or other restriction, can extend for years.[166] Schlanger notes that the vast overrepresentation of people with mental disabilities in restrictive housing units is frequently linked to the difficulties of prison authorities to manage these individuals in the general population, as well as the fact that once in isolation these individuals often decompensate, committing what are classed as disciplinary breaches.[167]

Regardless of the intent, however, such policies and practices have significant consequences. Beyond the direct impacts on the individual, placement within restricted housing may further reduce the prisoners' capacity to comply with prison regime, and often also has the consequence of limiting access to privileges, programmes and work release assignments, affecting chances of early parole.[168]

The Mandela Rules refer to solitary confinement, stating relevantly in Rule 45 that "the imposition of solitary confinement should be prohibited in the case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures." However the Rules do not deal with the issue of restrictive housing. It is not a simple matter, as there may be situations in which separate accommodation is, in all the circumstances, less confining than general accommodation. The adapted tool needs to be able to recognise the risks of discriminatory use of restricted housing and ensure that an individualised approach is taken in the case of prisoners with mental disabilities.

[163] APA 2012 cited in cited in Shalev 2014, 30.
[164] Shalev 2014.
[165] DRW 2016.
[166] Seevers 2016, cited by Schlanger 2017.
[167] Schlanger 2017, 4; citing Beck 2015 (relating that prisoners with mental illness reported having spent time in restrictive housing at about twice the rate of other prisoners). Schlanger also refers to Yale 2016 (tracing the placement of prisoners with a serious mental health issue in restrictive housing).
[168] Shalev 2014, 29.

5.1.2 Proposed new standards for Theme 3

Standard 3.1a Prison policies and practices recognise that additional safeguards are required to ensure consent by prisoners with mental disabilities to any aspect of treatment is freely given, and to accommodate their treatment preferences as far as possible.

Standard 3.2a Prison authorities and health staff demonstrate awareness of the importance of health staff maintaining and demonstrating their clinical independence. In relation to patients who are prisoners with mental disabilities, this includes adherence to prisoners' autonomy with regard to their own health and informed consent in the doctor-patient relationship.

Standard 3.3a Prisoners with mental disabilities can exercise their legal capacity and are given the support they may require to exercise their legal capacity.

Standard 3.4a Prisoners with mental disabilities have the same right to confidentiality and access to their personal health information as prisoners without mental disabilities, and are given the support they may require to exercise these rights.

Standard 3.5a Policies and practices recognise the tendency for prisoners with mental disabilities to be over-represented in isolated or restricted housing, and also the disproportionate impact of this on people with mental disabilities.

Standard 3.6a Measures are in place and actively applied to ensure that isolated or restrictive housing is not being used in a discriminatory manner, and to monitor the extent to which prisoners with mental disabilities are represented in restricted housing or isolation compared with prisoners without mental disabilities, including by monitoring cumulative periods.

Standard 3.7a Effective processes are in place to ensure appropriate consideration is given, on an individualised basis, to reasonable accommodation requests by prisoners with mental disabilities in relation to any decision that they

live in isolated or restrictive housing, and prisoners are supported to make these requests.

5.2 Theme 4: Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse

Standards under the current QualityRights tool

Standard 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect.

Standard 4.2 Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.

Standard 4.3 Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user.

Standard 4.4 No service user is subjected to medical or scientific experimentation without his or her informed consent.

Standard 4.5 Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse.

5.2.1 Standards 4.1 – 4.5 - commentary

This theme is referenced against Articles 15 and 16, relating to freedom from torture or cruel, inhuman or degrading treatment or punishment; and freedom from exploitation, violence and abuse. There are two broad areas in which prisoners with mental disabilities may be particularly at risk of infringements of these rights– in interactions with other prisoners and in interactions with the prison system and staff. There is evidence that prisoners with mental disabilities are vulnerable to extortion, exploitation, threats and physical and sexual abuse by other prisoners, and in particular to be manipulated in ways

that results in them being disciplined.[169] They are also far more likely to be injured in fights.[170]

As discussed further below, there is also evidence that disciplinary procedures can have a discriminatory impact on people with mental disabilities, which could in some circumstances amount to a breach of article 5 of the CRPD.

5.2.1.1 Screening

It is important for compliance with the obligations of the CRPD that those prisoners with mental disabilities are identified at the earliest stage through appropriate screening and information exchange. This issue does not specifically feature within the standards of the QualityRights tool, which is designed for application in institutions whose purpose is specifically to accommodate people who have been identified as having a mental disability.

Despite the importance of effective screening, there is evidence of systemic ineffectiveness of screening systems within prisons, even in countries with highly sophisticated criminal justice systems. This was separately described, for example, in two recent independent reviews of prison mental health care from the United Kingdom and the United States. The 2017 UK National Audit Office review of mental health in prisons[171] found that:

> *While clinical care is broadly judged to be good, there are weaknesses in the system for identifying prisoners who need mental health services. Prisoners are screened by prison and healthcare staff when they arrive in prison, but screening does not always identify mental health problems. Staff do not have access to GP records, which means they do not always know if a prisoner has been diagnosed with a mental illness…Once in prison, prison officers may detect changes in a prisoner's mental health. But staffing pressures make this difficult, and officers do not receive regular training to understand mental health conditions.*

Similarly the Inspector General of the U.S. Department of Justice found in 2017[172] that the Federal Bureau of Prisons (BOP):

[169] Schlanger 2017, p4; citing HRW 2003 (quoting Kupers & Toch 1999).
[170] Schlanger 2017, p4; citing James & Glaze 2006.
[171] GBR Gov 2017, 9.
[172] USA Gov 2017, ii.

> *cannot accurately determine the number of inmates who have mental illness because institution staff do not always document mental disorders. The BOP's [financial year] 2014 data estimates that approximately 12 percent of inmates have a history of mental illness; however, in 2015, the BOP's Chief Psychiatrist estimated, based on discussions with institutions' Psychology Services staffs, that approximately 40 percent of inmates have mental illness, excluding inmates with only personality disorder diagnoses. Similarly, one institution's Deputy Chief Psychologist estimated that 50 percent of that institution's inmates may have Antisocial Personality Disorder; nevertheless, we found that this disorder was documented for only about 3.3 percent of the BOP's total inmate population. Because mental health staffs do not always document inmates' mental disorders, the BOP is unable to ensure that it is providing appropriate care to them.*

It is important that the adapted QualityRights tool incorporate appropriate standards as to screening and recognise the increased vulnerability of prisoners with mental disability to abuse and exploitation.

5.2.1.2 Discipline

The highly rule-bound environment of prison discipline systems has the potential for significant impact on and discrimination against prisoners with mental disabilities, whose behaviour may be interpreted as violations of rules rather than a manifestation of their mental disability. Prisoners with mental disabilities are much more likely than other prisoners to be disciplined for assault,[173] and, as Shalev notes, for these prisoners minor incidents can readily escalate into serious matters, since prisoners' behaviour and apparent adherence to rules determines their progression through the prison system.[174] In prison discipline systems this often results in a vicious cycle, leading to use of restraint and prolonged stays in isolation.[175]

Rule 39 (3) of the Mandela Rules relevantly provides that:

> *Before imposing disciplinary sanctions, prison administrations shall consider whether and how a prisoner's mental illness or developmental disability may have contributed to his or her conduct and*

[173] Schlanger 2017, 4; citing James & Glaze 2006.
[174] Shalev 2014, 29.
[175] Shalev 2014, 29.

the commission of the offence or act underlying the disciplinary charge. Prison administrations shall not sanction any conduct of a prisoner that is considered to be the direct result of his or her mental illness or intellectual disability.

The adapted QualityRights tool should contain relevant specific standards reflecting the importance of screening and disciplinary sanctions for prisoners with mental disabilities.[176]

5.2.2 Proposed new standards for Theme 4

Standards 4.3 and 4.4 have been addressed under Theme 3, so will not be included in Theme 4. The following new standards are proposed:

Standard 4.1a Policies and procedures recognise that prisoners with mental disabilities may be disproportionately subjected to or impacted by from verbal, mental, physical and sexual abuse and physical and emotional neglect.

Standard 4.2a There is systematic screening using recognised tools of all prisoners on arrival at the prison by qualified staff to ensure that mental disabilities are detected, and this screening results in an individualised plan for the provision of health and other services needed by persons with mental disabilities.

Standard 4.3a Alternative methods are used in place of seclusion and restraint as a means of de-escalating potential crises, and these methods are designed to take into account the needs of people with mental disabilities in prison environments.

Standard 4.4a Effective policies and processes are in place to ensure that, before imposing disciplinary sanctions, prison authorities consider whether and how a prisoner's mental disability may have contributed to his or her conduct and the commission of the offence or act underlying the disciplinary charge. Prison authorities do not discipline any conduct of a

[176] Huber & o'rs 2015, 10; The US Department of Justice Office of the Inspector General has also emphasised the importance of ensuring the cumulative length of time that prisoners with mental disabilities spend in isolation, noting their over-representation in these units and the risk of this going unrecorded: USA Gov 2017, 30.

prisoner that is considered to be the direct result of his or her mental disability.

Standard 4.5a Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse, and these recognise the particular vulnerability of prisoners with mental disabilities to this treatment.

5.3 Theme 5: Live independently and be included in the community

Standards under the current QualityRights tool

- Standard 5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community.
- Standard 5.2 Service users can access education and employment opportunities.
- Standard 5.3 The right of service users to participate in political and public life and to exercise freedom of association is supported.
- Standard 5.4 Service users are supported in taking part in social, cultural, religious and leisure activities

5.3.1 Standards 5.1-5.4 - commentary

Theme 5 references Article 19 of the CRPD, which has a focus on non-discrimination in terms of inclusion in the community and the need to prevent isolation. The Article requires, among other things, that community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

There are two relevant elements to the concept of community life for prisoners with mental disabilities – the community inside prison and the community upon release from prison. Prison processes in both areas have the potential to discriminate against prisoners with mental illness.

Within prison there is evidence of prisoners with mental disabilities being excluded from programs, jobs and even parole, including as a matter of policy.[177] While there may be justifiable reasons for excluding a person with a mental disability from such activities, if the exclusion is done on the basis of the disability this will breach the non-discrimination requirement in Article 5 of the CRPD. Schlanger discusses this issue in the context of US disability legislation, which is comparable to the CRPD, and notes that such exclusion has been found to be justified "if necessary for the safe operation of its services, programs, or activities", but that any safety requirements must also be based on the "actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities." For a decision to exclude to be well-based it requires use of the best available evidence and an individualised approach.[178] Schlanger proposes in response that prison authorities adopt an approach of not excluding prisoners with disabilities from particular housing units, jobs, or any other programs "absent an individualized finding that a prisoner's participation poses significant safety risks that cannot be mitigated."[179]

Another key issue of community inclusion for prisoners with mental disabilities is their high vulnerability at the time of release from prison. There is extensive evidence that people recently released from prison experience high rates of mental health problems and a very high risk of death by suicide in this period.[180] A number of studies have identified the complex logistical, safety and health concerns which define the post-release period, where a key issue is these individuals' difficulties in accessing medical appointments and medication.[181] Binswanger et al note the strong connections between these factors and the deterioration in mental health of released prisoners, and their highly elevated rates of death.[182] A common theme from this research is the importance of transitional planning, including ensuring people can readily access necessary medication on release, to manage the significant risks facing released prisoners, particularly those with serious mental illness.[183]

[177] Schlanger 2017, 6-7, citing Seevers 2016.
[178] Schlanger 2017, 10
[179] Schlanger 2017, 10.
[180] Borschmann & o'rs 2016.
[181] See, for example Binswanger & o'rs 2011 and Pratt & o'rs 2006.
[182] Binswanger & o'rs 2011.
[183] Binswanger & o'rs 2011.

This is an area where the human rights of prisoners with mental disabilities are particularly at risk, and it is appropriate that this issue be included in the adapted QualityRights tool.

5.3.2 Proposed new standards for Theme 5

Standard 5.1a Policies and procedures recognise that aspects of prison life and the transition to the community will disproportionately impact on individuals with mental disability, and that reasonable accommodation must be considered to overcome barriers to their right to community involvement.

Standard 5.2a Prisoners with mental disabilities are not excluded from services, programs and opportunities on the basis of their disability. The needs of people with mental disabilities are reflected in program and service design.

Standard 5.3a Effective processes are in place to ensure appropriate consideration is given, on an individualised basis, to reasonable accommodation requests as to services, programs and opportunities by prisoners with mental disabilities, and prisoners are supported to make these requests.

Standard 5.4a Participation rates by prisoners with mental disabilities in programs, services and opportunities relevant to community involvement are monitored to identify any discrimination in access in practice.

Standard 5.5a Prison policies and procedures recognise the critical importance of effective discharge planning for prisoners with mental disabilities, and their disproportionate vulnerability during the post-release period.

Standard 5.6a Prison authorities undertake effective, systematic discharge planning for prisoners with mental disabilities, including providing adequate interim supplies of medication and support to obtain repeat prescriptions of medications in the immediate post-release period, recognising the practical difficulties of engaging with new health providers.

Chapter 6: Conclusion and next steps

This dissertation considered the following question:

> *How can the WHO QualityRights tool be adapted for the prison environment in a way that appropriately recognises the impact of the prison setting on imprisoned people with a mental disability?*

The formulation of this question was based on assumptions that, as states have committed to comply with the principle of equivalence, and as the CRPD imposes obligations of non-discrimination on states, it should be possible to develop a minimally-adapted version of the QualityRights tool to assist authorities in conducting internal reviews of prison mental health services.

The process of adapting the tool has disclosed some of the complexities of both the principle of equivalence and the non-discrimination obligation within the right to health and the CRPD. The literature contains mixed views about the principle of equivalence – on the one hand there is an acceptance that the principle is an important legal and conceptual link to the commitment that prisoners are entitled and deserving of health services on an equal basis to the rest of society. On the other hand, there are calls to move beyond the principle of equivalence. These are prompted by the inherent confusion of the meaning of the principle, and of the notion of health itself, in the prison setting, and by the difficulties of practically applying the principle of equivalence. However there is no consensus on the direction a move beyond the principle equivalence should take.

Differences of opinion are also evident in assumptions as to how the principle of equivalence should or does incorporate outcomes and processes. There is a general recognition in the literature that an effective concept of prison health equity must include health outcomes that reflect the greater health need of the prison population. However some authors, and this dissertation, have highlighted the importance of process in influencing both rights and health outcomes for prisoners with mental disabilities. While there is as yet no clear framework for how to incorporate the impact of prison and health processes in an effective concept of equivalence or equity, it seems apparent that ignoring process elements is likely to limit the sophistication of analysis.

As this dissertation has discussed, the CRPD offers a potential direction through this dilemma. It brings a new framework to the consideration of what the principle of equivalence means, and through this provides a bridge to the legal debate about the interpretation and application of the principle of substantive equality. To date the literature reflects very little consideration of how prison authorities should strategically respond to the requirements of the CRPD in relation to prisoners with mental disabilities. Yet the status of the CRPD as a set of legal obligations means that it needs to be considered in more than a merely theoretical way, and challenges to the state's provision of prison mental health services on CRPD grounds can be increasingly expected. The Mandela Rules are an example of how CRPD expectations are beginning to be brought into prison policy and process. However there is considerably more work to be done to understand how the CRPD and its requirements will impact on prison mental health services.

Scholarship on substantive equality may provide a means of deepening the understandings of how the principle of equivalence can move beyond its current limitations. As Fredman notes, while the meaning of substantive equality is itself deeply contested, the limitations of a formal interpretation of equality are well recognised.[184] Fredman's[185] approach of exploring substantive equality through a four-dimensional analytic framework suggests a useful approach for future work in developing the principle of equivalence. This considers the impacts of laws and policies in relation to (a) redressing disadvantage; (b) addressing stigma, stereotyping, prejudice, and violence; (c) enhancing voice and participation; and (d) accommodating difference and achieving structural change. Such an approach is likely to provide a more systematic approach to understanding the many dynamics and conflicts within the principle of equivalence.

Such an approach is likely to have much in common with two other approaches discussed in the dissertation. Firstly Schlanger's recommendations point the way towards a possible future framework based on the practical application of disability discrimination laws in a prison setting. Secondly Exworthy et al[186] suggest that a more nuanced understanding of the principle of equivalence could be developed through the AAAQ framework. A future

[184] Fredman 2016, p712.
[185] Fredman 2016.
[186] Exworthy & o'rs 2012.

research agenda would benefit from consideration of the degree to which these proposed approaches are complementary, overlapping or distinct.

This dissertation has attempted to engage constructively with some of the complexities of prison human rights, health and disability, to provide a useable adaptation of the QualityRights tool. As discussed in Chapter one, the methodology adopted has clear limitations, in that it was inherently subjective, was based on literature with acknowledged gaps, and has not been informed through consultation with stakeholders. The adapted tool should be treated cautiously as a tentative step towards a future version of a tool to assist stakeholders in assessing compliance with the some of the rights under the CRPD in a prison setting. Prior to any formal validation and piloting, the adapted tool should be critically reviewed by stakeholders with varied perspectives and specific experience of prison settings.

It is important to also note the pitfalls in attempts to identify standards or requirements applicable across diverse settings, noting that standards which are unachievable in a particular resourcing context are not helpful. This is particularly important to bear in mind in adapting a tool such as the QualityRights tool, which is intended to be applicable across Low and Middle Income Countries as well as High Income Countries. There are countless examples, both internationally and nationally, where prescription of standards or processes does not match the relevant infrastructure, culture or resourcing context, and results in the subversion or rejection of the prescribed standards.

This is aptly demonstrated by one of the findings of the 2017 review of the Federal Bureau of Prisons' (BOP) use of restricted housing for mentally ill prisoners. The review considered the results of the adoption by BOP of a new mental health policy in 2014 which increased standards of care. It found that following the introduction of the policy the records showed, surprisingly, a 30% reduction in the number of prisoners receiving regular mental health treatment.[187] The Office of the Inspector General considered reasons for this reduction and concluded that:

[187] USA Gov 2017, pii.

> *Based on our review, it appears that mental health staff may have reduced the number of inmates, including those in [Restrictive Housing Units], who must receive regular mental health treatment because they did not have the necessary staffing resources to meet the policy's increased treatment standards.*

Such situations highlight the importance of any proposed standards relating to prison mental health being subjected to honest, critical review and piloting across multiple contexts and resource settings.

Finally, it is hoped that an instrument such as an adapted QualityRights tool may offer a means of identifying otherwise under-recognised impacts on prisoners with mental disorders, and highlighting issues where the rights and obligations within the CRPD may be engaged. If used alongside other tools directed at assessing health equity through outcomes, it may contribute to a broader effort of creating a more nuanced understanding of the principle of equivalence and CRPD obligations in prison settings, and identifying aspects of a future research agenda.

Appendix: Extracts from Convention on the Rights of Persons with Disabilities

Article 1 Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 2 Definitions

For the purposes of the present Convention:

"Communication" includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology;

"Language" includes spoken and signed languages and other forms of non spoken languages;

"Discrimination on the basis of disability" means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation;

"Reasonable accommodation" means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms;

"Universal design" means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. "Universal design" shall not exclude assistive devices for particular groups of persons with disabilities where this is needed.

Article 3 General principles

The principles of the present Convention shall be:

(a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;

(b) Non-discrimination;

(c) Full and effective participation and inclusion in society;

(d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;

(e) Equality of opportunity;

(f) Accessibility;

(g) Equality between men and women;

(h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Article 4 General obligations

1. States Parties undertake to ensure and promote the full realization of all human rights and fundamental freedoms for all persons with disabilities without discrimination of any kind on the basis of disability. To this end, States Parties undertake:
   (a) To adopt all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present Convention;
   (b) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities;
   (c) To take into account the protection and promotion of the human rights of persons with disabilities in all policies and programmes;
   (d) To refrain from engaging in any act or practice that is inconsistent with the present Convention and to ensure that public authorities and institutions act in conformity with the present Convention;
   (e) To take all appropriate measures to eliminate discrimination on the basis of disability by any person, organization or private enterprise;
   (f) To undertake or promote research and development of universally designed goods, services, equipment and facilities, as defined in article 2 of the present Convention, which should require the minimum possible adaptation and the least cost to meet the specific needs of a person with disabilities, to promote their availability and use, and to promote universal design in the development of standards and guidelines;
   (g) To undertake or promote research and development of, and to promote the availability and use of new technologies, including information and communications technologies, mobility aids, devices and assistive technologies, suitable for persons with disabilities, giving priority to technologies at an affordable cost;
   (h) To provide accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities;
   (i) To promote the training of professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights.
2. With regard to economic, social and cultural rights, each State Party undertakes to take measures to the maximum of its available resources and, where needed, within the framework of international cooperation, with a view to achieving progressively the full realization of these rights, without prejudice to those obligations contained in the present Convention that are immediately applicable according to international law.
3. In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations.
4. Nothing in the present Convention shall affect any provisions which are more conducive to the realization of the rights of persons with disabilities and which may be contained in the law of a State Party or international law in force for that State. There shall be no restriction upon or derogation from any of the human rights and fundamental freedoms recognized or existing in any State Party to the present Convention pursuant to law, conventions, regulation or custom on the pretext that the present Convention does not recognize such rights or freedoms or that it recognizes them to a lesser extent.
5. The provisions of the present Convention shall extend to all parts of federal States without any limitations or exceptions.

Article 5 Equality and non-discrimination

1. States Parties recognize that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
3. In order to promote equality and eliminate discrimination, States Parties shall take all appropriate steps to ensure that reasonable accommodation is provided.
4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present Convention.

Article 6 Women with disabilities

1. States Parties recognize that women and girls with disabilities are subject to multiple discrimination, and in this regard shall take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms.
2. States Parties shall take all appropriate measures to ensure the full development, advancement and empowerment of women, for the purpose of guaranteeing them the exercise and enjoyment of the human rights and fundamental freedoms set out in the present Convention.

Article 7 Children with disabilities

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

Article 8 Awareness-raising

1. States Parties undertake to adopt immediate, effective and appropriate measures:
   (a) To raise awareness throughout society, including at the family level, regarding persons with disabilities, and to foster respect for the rights and dignity of persons with disabilities;
   (b) To combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life;
   (c) To promote awareness of the capabilities and contributions of persons with disabilities.
2. Measures to this end include:
   (a) Initiating and maintaining effective public awareness campaigns designed:
      (i) To nurture receptiveness to the rights of persons with disabilities;
      (ii) To promote positive perceptions and greater social awareness towards persons with disabilities;
      (iii) To promote recognition of the skills, merits and abilities of persons with disabilities, and of their contributions to the workplace and the labour market;
   (b) Fostering at all levels of the education system, including in all children from an early age, an attitude of respect for the rights of persons with disabilities;
   (c) Encouraging all organs of the media to portray persons with disabilities in a manner consistent with the purpose of the present Convention;
   (d) Promoting awareness-training programmes regarding persons with disabilities and the rights of persons with disabilities.

Article 9 Accessibility

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:
   (a) Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
   (b) Information, communications and other services, including electronic services and emergency services.
2. States Parties shall also take appropriate measures:
   (a) To develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
   (b) To ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
   (c) To provide training for stakeholders on accessibility issues facing persons with disabilities;
   (d) To provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
   (e) To provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
   (f) To promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
   (g) To promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
   (h) To promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

Article 10 Right to life

States Parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others.

Article 11 Situations of risk and humanitarian emergencies

States Parties shall take, in accordance with their obligations under international law, including international humanitarian law and international human rights law, all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.

Article 12 Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human

rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

Article 13 Access to justice

1. States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.
2. In order to help to ensure effective access to justice for persons with disabilities, States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff.

Article 14 Liberty and security of person

1. States Parties shall ensure that persons with disabilities, on an equal basis with others:
   (a) Enjoy the right to liberty and security of person;
   (b) Are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.
2. States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the present Convention, including by provision of reasonable accommodation.

Article 15 Freedom from torture or cruel, inhuman or degrading treatment or punishment

1. No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation.
2. States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

Article 16 Freedom from exploitation, violence and abuse

1. States Parties shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects.
2. States Parties shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring, inter alia, appropriate forms of gender- and age-sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognize and report instances of exploitation, violence and abuse. States Parties shall ensure that protection services are age-, gender- and disability-sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

5. States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

Article 17 Protecting the integrity of the person

Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Article 18 Liberty of movement and nationality

1. States Parties shall recognize the rights of persons with disabilities to liberty of movement, to freedom to choose their residence and to a nationality, on an equal basis with others, including by ensuring that persons with disabilities:
   (a) Have the right to acquire and change a nationality and are not deprived of their nationality arbitrarily or on the basis of disability;
   (b) Are not deprived, on the basis of disability, of their ability to obtain, possess and utilize documentation of their nationality or other documentation of identification, or to utilize relevant processes such as immigration proceedings, that may be needed to facilitate exercise of the right to liberty of movement;
   (c) Are free to leave any country, including their own;
   (d) Are not deprived, arbitrarily or on the basis of disability, of the right to enter their own country.

2. Children with disabilities shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by their parents.

Article 19 Living independently and being included in the community

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

Article 20 Personal mobility

States Parties shall take effective measures to ensure personal mobility with the greatest possible independence for persons with disabilities, including by:

(a) Facilitating the personal mobility of persons with disabilities in the manner and at the time of their choice, and at affordable cost;

(b) Facilitating access by persons with disabilities to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;

(c) Providing training in mobility skills to persons with disabilities and to specialist staff working with persons with disabilities;

(d) Encouraging entities that produce mobility aids, devices and assistive technologies to take into account all aspects of mobility for persons with disabilities.

Article 21 Freedom of expression and opinion, and access to information

States Parties shall take all appropriate measures to ensure that persons with disabilities can exercise the right to freedom of expression and opinion, including the freedom to seek, receive and impart information and ideas on an equal basis with others and through all forms of communication of their choice, as defined in article 2 of the present Convention, including by:

(a) Providing information intended for the general public to persons with disabilities in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost;

(b) Accepting and facilitating the use of sign languages, Braille, augmentative and alternative communication, and all other accessible means, modes and formats of communication of their choice by persons with disabilities in official interactions;

(c) Urging private entities that provide services to the general public, including through the Internet, to provide information and services in accessible and usable formats for persons with disabilities;

(d) Encouraging the mass media, including providers of information through the Internet, to make their services accessible to persons with disabilities;

(e) Recognizing and promoting the use of sign languages.

Article 22 Respect for privacy

1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.

2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

Article 23 Respect for home and the family

1. States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:
   (a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;
   (b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;

(c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

2. States Parties shall ensure the rights and responsibilities of persons with disabilities, with regard to guardianship, wardship, trusteeship, adoption of children or similar institutions, where these concepts exist in national legislation; in all cases the best interests of the child shall be paramount. States Parties shall render appropriate assistance to persons with disabilities in the performance of their child-rearing responsibilities.

3. States Parties shall ensure that children with disabilities have equal rights with respect to family life. With a view to realizing these rights, and to prevent concealment, abandonment, neglect and segregation of children with disabilities, States Parties shall undertake to provide early and comprehensive information, services and support to children with disabilities and their families.

4. States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. In no case shall a child be separated from parents on the basis of a disability of either the child or one or both of the parents.

5. States Parties shall, where the immediate family is unable to care for a child with disabilities, undertake every effort to provide alternative care within the wider family, and failing that, within the community in a family setting.

Article 24 Education

1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning directed to:
   (a) The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;
   (b) The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;
   (c) Enabling persons with disabilities to participate effectively in a free society.

2. In realizing this right, States Parties shall ensure that:
   (a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;
   (b) Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;
   (c) Reasonable accommodation of the individual's requirements is provided;
   (d) Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;
   (e) Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion.

3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including:
   (a) Facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring;
   (b) Facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community;
   (c) Ensuring that the education of persons, and in particular children, who are blind, deaf or deafblind, is delivered in the most appropriate languages and modes and means of

communication for the individual, and in environments which maximize academic and social development.

4. In order to help ensure the realization of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.

5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

Article 25 Health

States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

(a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;

(b) Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;

(c) Provide these health services as close as possible to people's own communities, including in rural areas;

(d) Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;

(e) Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;

(f) Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.

Article 26 Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:
   (a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;
   (b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Article 27 Work and employment

1. States Parties recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps, including through legislation, to, inter alia:
   (a) Prohibit discrimination on the basis of disability with regard to all matters concerning all forms of employment, including conditions of recruitment, hiring and employment, continuance of employment, career advancement and safe and healthy working conditions;
   (b) Protect the rights of persons with disabilities, on an equal basis with others, to just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances;
   (c) Ensure that persons with disabilities are able to exercise their labour and trade union rights on an equal basis with others;
   (d) Enable persons with disabilities to have effective access to general technical and vocational guidance programmes, placement services and vocational and continuing training;
   (e) Promote employment opportunities and career advancement for persons with disabilities in the labour market, as well as assistance in finding, obtaining, maintaining and returning to employment;
   (f) Promote opportunities for self-employment, entrepreneurship, the development of cooperatives and starting one's own business;
   (g) Employ persons with disabilities in the public sector;
   (h) Promote the employment of persons with disabilities in the private sector through appropriate policies and measures, which may include affirmative action programmes, incentives and other measures;
   (i) Ensure that reasonable accommodation is provided to persons with disabilities in the workplace;
   (j) Promote the acquisition by persons with disabilities of work experience in the open labour market;
   (k) Promote vocational and professional rehabilitation, job retention and return-to-work programmes for persons with disabilities.
2. States Parties shall ensure that persons with disabilities are not held in slavery or in servitude, and are protected, on an equal basis with others, from forced or compulsory labour.

Article 28 Adequate standard of living and social protection

1. States Parties recognize the right of persons with disabilities to an adequate standard of living for themselves and their families, including adequate food, clothing and housing, and to the continuous improvement of living conditions, and shall take appropriate steps to safeguard and promote the realization of this right without discrimination on the basis of disability.
2. States Parties recognize the right of persons with disabilities to social protection and to the enjoyment of that right without discrimination on the basis of disability, and shall take appropriate steps to safeguard and promote the realization of this right, including measures:
   (a) To ensure equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs;

(b) To ensure access by persons with disabilities, in particular women and girls with disabilities and older persons with disabilities, to social protection programmes and poverty reduction programmes;

(c) To ensure access by persons with disabilities and their families living in situations of poverty to assistance from the State with disability-related expenses, including adequate training, counselling, financial assistance and respite care;

(d) To ensure access by persons with disabilities to public housing programmes;

(e) To ensure equal access by persons with disabilities to retirement benefits and programmes.

Article 29 Participation in political and public life

States Parties shall guarantee to persons with disabilities political rights and the opportunity to enjoy them on an equal basis with others, and shall undertake:

(a) To ensure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others, directly or through freely chosen representatives, including the right and opportunity for persons with disabilities to vote and be elected, inter alia, by:

(i) Ensuring that voting procedures, facilities and materials are appropriate, accessible and easy to understand and use;

(ii) Protecting the right of persons with disabilities to vote by secret ballot in elections and public referendums without intimidation, and to stand for elections, to effectively hold office and perform all public functions at all levels of government, facilitating the use of assistive and new technologies where appropriate;

(iii) Guaranteeing the free expression of the will of persons with disabilities as electors and to this end, where necessary, at their request, allowing assistance in voting by a person of their own choice;

(b) To promote actively an environment in which persons with disabilities can effectively and fully participate in the conduct of public affairs, without discrimination and on an equal basis with others, and encourage their participation in public affairs, including:

(i) Participation in non-governmental organizations and associations concerned with the public and political life of the country, and in the activities and administration of political parties;

(ii) Forming and joining organizations of persons with disabilities to represent persons with disabilities at international, national, regional and local levels.

Article 30 Participation in cultural life, recreation, leisure and sport

1. States Parties recognize the right of persons with disabilities to take part on an equal basis with others in cultural life, and shall take all appropriate measures to ensure that persons with disabilities:

(a) Enjoy access to cultural materials in accessible formats;

(b) Enjoy access to television programmes, films, theatre and other cultural activities, in accessible formats;

(c) Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance.

2. States Parties shall take appropriate measures to enable persons with disabilities to have the opportunity to develop and utilize their creative, artistic and intellectual potential, not only for their own benefit, but also for the enrichment of society.

3. States Parties shall take all appropriate steps, in accordance with international law, to ensure that laws protecting intellectual property rights do not constitute an unreasonable or discriminatory barrier to access by persons with disabilities to cultural materials.

4. Persons with disabilities shall be entitled, on an equal basis with others, to recognition and support of their specific cultural and linguistic identity, including sign languages and deaf culture.

5. With a view to enabling persons with disabilities to participate on an equal basis with others in recreational, leisure and sporting activities, States Parties shall take appropriate measures:
   (a) To encourage and promote the participation, to the fullest extent possible, of persons with disabilities in mainstream sporting activities at all levels;
   (b) To ensure that persons with disabilities have an opportunity to organize, develop and participate in disability-specific sporting and recreational activities and, to this end, encourage the provision, on an equal basis with others, of appropriate instruction, training and resources;
   (c) To ensure that persons with disabilities have access to sporting, recreational and tourism venues;
   (d) To ensure that children with disabilities have equal access with other children to participation in play, recreation and leisure and sporting activities, including those activities in the school system;
   (e) To ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities.

Bibliography

APA, 2012. American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness*, Approved by the Board of Trustees, December 2012. Arlington (USA). Available <https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-prisoners-segregation.pdf> 10 Sep 2017.

APT, ud-a. *Health care services*, Detention Focus Database. Geneva (CHF): Association for the Prevention of Torture. Available <www.apt.ch/detention-focus/en/detention_issues/55/?vg=-1> 11 Jul 2017.

------, ud-b. *Health care staff*, Detention Focus Database. Geneva (CHF): Association for the Prevention of Torture. Available <www.apt.ch/detention-focus/en/detention_issues/57/> 10 Sep 2017.

AUS Gov, 2012. *Initial reports submitted by States parties under article 35 of the Convention: Australia*, UN doc CRPD/C/AUS/1, 7 June 2012. Geneva (CHE): United Nations. Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fAUS%2f1&Lang=en> 10 Sep 2017.

------, 2015. Australian Institute of Health and Welfare, *The health of Australia's prisoners 2015*, 27 November 2015. Canberra: Australian Government. Available <www.aihw.gov.au/publication-detail/?id=60129553527> 11 Jul 2017.

------, 2016a. Corrective Services Administrators Council, *2016 Indigenous Strategic Framework*, CSAC Indigenous Issues Working Group (Senior officers working in Correctional Services). Melbourne (AUS): Victorian Government. Available <http://assets.justice.vic.gov.au/corrections/resources/8ce31c9b-b394-4a8d-af69-eb1b60ee09c6/csac+indigenous+strategic+framework+2016+final+version.pdf> 10 Sep 2017.

------, 2016b. Australian Bureau of Statistics, *Prisoners in Australia*, Release 4517.0, 8 December 2016. Canberra: Australian Government. Available <www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2016~Main%20Features~Imprisonment%20rates~12> 15 Sep 2017.

Bastick, M & Townhead, L, 2008. *Women in Prison: A Commentary on the UN Standard Minimum Rules for the Treatment of Prisoners*, Quaker United Nations Office, June 2008. Geneva (CHE). Available <www.peacewomen.org/assets/file/Resources/NGO/HR_Prisoners_QUNO_2008.pdf> 10 Sep 2017.

Baybutt, M; Acin, E; Hayton, P & Dooris, M, 2014. 'Promoting health in prisons: a settings approach', in Enggist, S, Møller, L, Galea, G & Udesen, C (eds.) *Prisons and Health*. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health/report-by-chapters/chapter-21.-promoting-health-in-prisons-a-settings-approach> 13 Sep 2017.

Baybutt, M & Chemlal, K, 2016. 'Health-promoting prisons: theory to practice' 23(1_suppl) *Global Health Promotion* 66.

Beck, A, 2015. Office of Justice Programs (Bureau of Justice Statistics), *Use of Restrictive Housing in U.S. Prisons and Jails, 2011–12*, Special Report NCJ 249209, October 2015. U.S. Department of Justice. Available <https://www.bjs.gov/content/pub/pdf/urhuspj1112.pdf> 10 Sep 2017.

Binswanger, I & o'rs, 2011. '"From the prison door right to the sidewalk, everything went downhill," a qualitative study of the health experiences of recently released inmates' 34(4) *International Journal Law Psychiatry* 249.

Birmingham, L; Wilson, S & Adshead, G, 2006. 'Prison medicine: ethics and equivalence' 188(1) *The British Journal of Psychiatry* 4.

Borschmann, R & o'rs, 2016. 'Self-harm following release from prison: A prospective data linkage study' 51(3) *Australian & New Zealand Journal of Psychiatry* 250.

Bowen, RA; Rogers, A & Shaw, J, 2009. 'Medication management and practices in prison for people with mental health problems: A qualitative study' 3(1) *International Journal of Mental Health Systems* 24.

CAMH, 2014. Centre for Addiction and Mental Health, *Think Global: CAMH partners with international agencies to improve mental health in lower income countries*. Ottawa: PR Newswire Association LLC.

Charles, A & Draper, H, 2012. "Equivalence of care' in prison medicine: is equivalence of process the right measure of equity?' 38(4) *Journal of Medical Ethics* 215.

COAG, 2011. Commonwealth of Australia and the States and Territories, *National Health Reform Agreement*, July 2011. Canberra: Council of Australian Governments. Available <www.federalfinancialrelations.gov.au/content/npa/health/_archive/national-agreement.pdf> 10 Jul 2017.

CoE, 2006. Council of Europe, *European Prison Rules*, June 2006. Strasbourg. Available <https://rm.coe.int/16806f3d4f> 15 Sep 2017.

Coyle, A, 2014. 'Standards in prison health: the prisoner as a patient', in Enggist, S, Møller, L, Galea, G & Udesen, C (eds.) *Prisons and Health*, pp6-10. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/__data/assets/pdf_file/0008/249191/Prisons-and-Health,-2-Standards-in-prison-health-the-prisoner-as-a-patient.pdf> 10 Sep 2017.

Coyle, A; Fair, H; Jacobson, J & Walmsley, R, 2016. *Imprisonment worldwide: The current situation and an alternative future.* Bristol (GBR): Policy Press.

Criminal Law (Mentally Impaired Accused) Act (AUS). *Criminal Law (Mentally Impaired Accused) Act 1996*, Western Australian Parliament, No. 70 of 1996, 13 November 1996. Available <https://www.slp.wa.gov.au/pco/prod/filestore.nsf/FileURL/mrdoc_28300.htm/$FILE/Criminal%20Law%20(Mentally%20Impaired%20Accused)%20Act%201996%20-%20%5B03-h0-00%5D.html?OpenElement> 10 Sep 2017.

CRPD, 2006. UN General Assembly, *Convention on the Rights of Persons with Disabilities*, 2515 UNTS 3 (in force 3 May 2008). Available <www.un-documents.net/a61r106.htm> 16 Sep 2009.

D.G. -v- POL (2013). European Court of Human Rights *Case of D.G. v. Poland* Application no. 45705/07 (12 May 2013). Available <http://hudoc.echr.coe.int/eng?i=001-116410> 10 Sep 2017.

Dawson, J, 2015. 'A realistic approach to assessing mental health laws' compliance with the UNCRPD' 40 *Int J Law Psychiatry* 79.

De Viggiani, N, 2007. 'Unhealthy prisons: exploring structural determinants of prison health' 29(1) *Sociology of Health & Illness* 115.

Devereux, S & Sabates-Wheeler, R, 2004. *Transformative Social Protection*, IDS Working Paper 232, October 2004. Brighton (GBR): Institute of Development Studies.

Dober, G, 2014. 'Equivalency of Care Difficult to Attain in U.S. Prisons' 14(7) *American Journal of Bioethics* 17.

Dolan, K & o'rs, 2007. 'HIV in prison in low-income and middle-income countries' 7(1) *The Lancet Infectious Diseases* 32. Available <www.sciencedirect.com/science/article/pii/S1473309906706855> 15 Sep 2017.

DRW, 2016. *Cruel But Not Unusual: Solitary Confinement in Washington's County Jails*, Amplifying Voices of Inmates with Disabilities (AVID) Project, November 2016. Seattle (USA): Disability Rights Washington. Available <www.disabilityrightswa.org/sites/default/files/uploads/CruelbutNotUnusual_November2016.pdf> 10 Sep 2017.

Durcan, G & Zwemstra, J, 2014. 'Mental health in prison', in Enggist, S, Møller, L, Galea, G & Udesen, C (eds.) *Prisons and Health*, pp87-95. Geneva: WHO Regional Office for Europe. Available <www.euro.who.int/__data/assets/pdf_file/0017/249200/Prisons-and-Health,-11-Mental-health-in-prison.pdf> 15 Sep 2017.

ECHR, 2017a. Press Unit, *Detention and mental health*, Factsheet, July 2017. Strasbourg (FRA): European Court of Human Rights. Available <www.echr.coe.int/Documents/FS_Detention_mental_health_ENG.pdf> 10 Sep 2017.

------, 2017b. Press Unit, *Prisoners' health-related rights*, Factsheet, July 2017. Strasbourg (FRA): European Court of Human Rights. Available <www.echr.coe.int/Documents/FS_Prisoners_health_ENG.pdf> 10 Sep 2017.

------, ud. European Court of Human Rights, *European Convention on Human Rights*. Strasbourg (FRA). Available <www.echr.coe.int/pages/home.aspx?p=basictexts> 10 Sep 2017.

Edney, R, 2001. 'Judicial Deference to the Expertise of Correctional Administrators: The Implications For Prisoners' Rights' 7(1) *Australian Journal of Human Rights* 91. Available <www.austlii.edu.au/au/journals/AUJlHRights/2001/5.html> 10 Jul 2017.

Enggist, S; Møller, L; Galea, G & Udesen, C (eds.), 2014. *Prisons and Health*. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health/report-by-chapters> 10 Sep 2017.

Exworthy, T; Samele, C; Urquía, N & Forrester, A, 2012. 'Asserting Prisoners' Right to Health: Progressing Beyond Equivalence' 63(3) *Psychiatric Services* 270.

Fazel, S; Grann, M; Kling, B & Hawton, K, 2011. 'Prison suicide in 12 countries: an ecological study of 861 suicides during 2003-2007' 46(3) *Social Psychiatry & Psychiatric Epidemiology* 191.

Fazel, S & o'rs, 2016. 'Mental health of prisoners: prevalence, adverse outcomes, and interventions' 9(3) *The Lancet Psychiatry* 871.

Forrester, A & o'rs, 2013. 'Variations in prison mental health services in England and Wales' 36(3-4) *International journal of law and psychiatry* 326.

Frawley, P & Naylor, B, 2014. 'Human Rights and People with Disabilities in Closed Environments', in Naylor, B, Debeljak, J & Mackay, A (eds.) *Human Rights in Closed Environments*. Sydney (AUS): Federation Press.

Fredman, S, 2016. 'Substantive equality revisited' 14(3) *International Journal Of Constitutional Law* 712.

Freeman, M & o'rs, 2015. 'Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities' 2(9) *Lancet Psychiatry* 844.

Gatherer, A; Enggist, S & Møller, L, 2014. 'The essentials about prisons and health', in Enggist, S, Møller, L, Galea, G & Udesen, C (eds.) *Prisons and Health*, pp1-5. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/__data/assets/pdf_file/0005/249188/Prisons-and-Health.pdf> 10 Jul 2017.

GBR Gov, 2017. National Audit Office, *Mental health in prisons*, Report by the Comptroller and Auditor General, 29 June 2017. Her Majesty's Prison & Probation Service (NHS England and Public Health England). Available <https://www.nao.org.uk/wp-content/uploads/2017/06/Mental-health-in-prisons.pdf> 10 Sep 2017.

Gen Comm 1, 2014. Committee on the Rights of Persons with Disabilities, *General Comment No 1 (Article 12: Equal recognition before the law)*, UN doc CRPD/C/GC/1. Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/1&Lang=en> 10 Sep 2017.

Gen Comm 2, 2008. Committee Against Torture, *General Comment No. 2, Implementation of article 2 by States parties*, UN doc CAT/C/GC/2. Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2fC%2fGC%2f2&Lang=en> 10 Sep 2017.

Gen Comm 21, 1993. Human Rights Committee, *General Comment No. 21 - Humane treatment of persons deprived of their liberty (Article 10)*, UN doc CCPR/C/21/Rev.1/Add.13. Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCCPR%2fGEC%2f4731&Lang=en> 10 Sep 2017.

Gen Comm 33, 2015. Nations, U, *General Comment 33: General recommendation on women's access to justice*, UN doc CEDAW/C/GC/33. Available <http://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/CEDAW_C_GC_33_7767_E.pdf> 15 Sep 2017.

Gen Comm 14, 2000. Committee on Economic Social & Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, UN doc E/C.12/2000/4. Available <www.unhchr.ch/tbs/doc.nsf/(Symbol)/40d009901358b0e2c1256915005090be?Opendocument> 23 Apr 2009.

Gen Comm 29, 2001. Human Rights Committee, *General Comment No. 29: States of Emergency*, UN doc CCPR/C/21/Rev.1/Add.11. Available <www.unhchr.ch/tbs/doc.nsf/(Symbol)/71eba4be3974b4f7c1256ae200517361?Opendocument> 24 Apr 2009.

Gen Comm 31, 2004. Human Rights Committee, *General Comment No. 31: Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN doc CCPR/C/21/Rev.1/Add.13. Available <www.unhchr.ch/tbs/doc.nsf/(Symbol)/CCPR.C.21.Rev.1.Add.13.En?Opendocument> 24 Apr 2009.

Gladkiy -v- RUS (2010). European Court of Human Rights, *Case of Gladkiy v. Russia* Application no. 3242/03 (21 December 2010). Available <http://hudoc.echr.coe.int/eng?i=001-102337> 10 Sep 2017.

Goffman, E, 1961. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York (USA): Anchor Books.

Graham, L, 2017. *The European Court of Human Rights and the Emerging Right to Health*, OxHRH Blog, 11 May 2017. Oxford Human Rights Hub. Available <http://ohrh.law.ox.ac.uk/the-european-court-of-human-rights-and-the-emerging-right-to-health> 10 Sep 2017.

Grassian, S, 2006. 'Psychiatric Effects of Solitary Confinement' 22(1) *Washington University Journal of Law & Policy* 325. Available <http://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24> 10 Sep 2017.

Haney, C, 2003. 'Mental Health Issues in Long-Term Solitary and "Supermax" Confinement' 49(1) *Crime & Delinquency* 124.

Harding, R, 1998. 'In the Belly of the Beast: A Comparison of the Evolution and Status of Prisoners' Rights in the United States and Europe' 27(1) *Georgia Journal of International and Comparative Law* 1. Available <http://digitalcommons.law.uga.edu/gjicl/vol27/iss1/2 > 10 Sep 2017.

Hatton, D & Fisher, A, 2008. 'Incarceration and the New Asylums: Consequences for the Mental Health of Women Prisoners' 29(12) *Issues in Mental Health Nursing* 1304.

Health Insurance Act 1973 (AUS). *Health Insurance Act 1973*, Cwth, No. 42 of 1974, 8 August 1974. Available <https://www.legislation.gov.au/Details/C2016C01004> 10 Jul 2017.

Heffernan, E, 2016. *The mental health of Aboriginal and Torres Strait Islander people in custody*. School of Public Health PhD thesis, University of Queensland. Available <https://espace.library.uq.edu.au/view/UQ:400903> 10 Sep 2017.

Howerton, A & o'rs, 2007. 'Understanding help seeking behaviour among male offenders: qualitative interview study' 334(7588) *BMJ* 303.

HRW, 2003. *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*. New York (USA): Human Rights Watch. Available <https://www.hrw.org/reports/2003/usa1003/usa1003.pdf> 10 Sep 2017.

Huber, A; Bernath, B; Allen, R & Delaplace, E, 2015. Penal Reform International, *Balancing security and dignity in prisons: a framework for preventive monitoring*, EIDHR Project Strengthening Institutions and Building Civil Society Capacity to Combat Torture in 9 CIS Countries. London: Penal Reform International and Association for the Prevention of Torture. Available <https://cdn.penalreform.org/wp-content/uploads/2016/01/security-dignity-2nd-ed-v6.pdf> 11 Jul 2017.

Hunt, P & Mesquita, J, 2006. 'Mental Disabilities and the Human Right to the Highest Attainable Standard of Health1' 28(2) *Human Rights Quarterly* 332.

Hurst, S, 2014. 'Equivalent Confusions' 14(7) *American Journal of Bioethics* 15.

Hurtado -v- CHF (1994). European Court of Human Rights *Case of Hurtado v. Switzerland* Application no. 17549/90 (28 January 1994). Available <http://hudoc.echr.coe.int/eng?i=001-57868> 10 Jul 2017.

ICCPR, 1966. UN General Assembly, *International Covenant on Civil and Political Rights*, 999 UNTS 171 (in force 23 Mar 1976). Available <www.un-documents.net/iccpr.htm> 26 Aug 2011.

ICESCR, 1966. UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 993 UNTS 3 (in force 3 Jan 1976). Available <www.un-documents.net/icescr.htm> 26 Aug 2011.

James, D & Glaze, L, 2006. Office of Justice Programs (Bureau of Justice Statistics), *Mental Health Problems of Prison and Jail Inmates*, Special Report NCJ 213600, September 2006. U.S. Department of Justice. Available <https://www.bjs.gov/content/pub/pdf/mhppji.pdf> 10 Sep 2017.

Jordan, M, 2011. 'The prison setting as a place of enforced residence, its mental health effects, and the mental healthcare implications' 17(5) *Health & place* 1061.

Jotterand, F & Wangmo, T, 2014a. 'The Principle of Equivalence Reconsidered: Assessing the Relevance of the Principle of Equivalence in Prison Medicine' 14(7) *American Journal of Bioethics* 4.

------, 2014b. 'Response to Open Peer Commentaries on "The Principle of Equivalence Reconsidered: Assessing the Relevance of the Principle of Equivalence in Prison Medicine"' 14(11) *American Journal of Bioethics* W3.

Junewicz, A, 2014. 'Shackled: Providing Health Care to Prisoners Outside of Prison' 14(7) *American Journal of Bioethics* 13.

Keenan -v- GBR (2001). European Court of Human Rights *Case of Keenan v. The United Kingdom* Application no. 27229/95 (3 April 2001). Available <http://hudoc.echr.coe.int/eng?i=001-59365> 10 Jul 2017.

Kupers, T & Toch, H, 1999. *Prison Madness: The Mental Health Crisis Behind Bars and What We Must Do About it.* New York (USA): John Wiley & Sons Inc.

Lawson, A, 2012. 'Disability equality, reasonable accommodation and the avoidance of ill-treatment in places of detention: the role of supranational monitoring and inspection bodies' 16(6) *The International Journal of Human Rights* 845. Available <http://dx.doi.org/10.1080/13642987.2012.706003>.

Lines, R, 2006. 'From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons' 2(4) *International Journal of Prisoner Health* 269.

------, 2008. 'The right to health of prisoners in international human rights law' 4(1) *International Journal of Prisoner Health* 3.

Lines, R; Stöver, H; Donochoe, M & Lazarus, J, 2009. 'Monitoring harm reduction in European prisons via the Dublin Declaration' 5(4) *International Journal of Prisoner Health* 251.

Lord, J & Brown, R, 2011. 'The Role of Reasonable Accommodation in Securing Substantive Equality for Persons with Disabilities: The UN Convention on the Rights of Persons with Disabilities', in Rioux, M, Basser Marks, LA & Jones, M (eds.) *Critical Perspectives on Human Rights and Disability Law*, pp273-308 (10.2139/ssrn.1618903. Leiden (NLD): Brill | Nijhoff.

Markov, D & Doichinova, M, 2014. *Prison Conditions Monitoring Index*, Methodology and Pilot Results. Sofia: Center for the Study of Democracy. Available <www.ub.edu/ospdh/sites/default/files/documents/PCMI.%20Methodology%20and%20pilot%20results.pdf> 10 Sep 2017.

Minelotti, A; Toro, O; Alvarado, R & Rayo, X, 2015. 'Differences on perceptions of quality of care and respect for rights in mental health between user, family and staff' 72(4) *Revista de la Facultad de Ciencias Medicas (Cordoba, Argentina)* 261.

Modvig, J, 2014. 'Violence, sexual abuse and torture in prisons', in Enggist, S, Møller, L, Galea, G & Udesen, C (eds.) *Prisons and Health*, pp19-26. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/__data/assets/pdf_file/0010/249193/Prisons-and-Health,-4-Violence,-sexual-abuse-and-torture-in-prisons.pdf?ua=1> 10 Sep 2017.

Møller, L & o'rs, 2012. *Health in prisons*, A WHO guide to the essentials in prison health. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf> 15 Sep 2017.

Moloney, K; Van den Bergh, B & Moller, L, 2009. 'Women in prison: The central issues of gender characteristics and trauma history' 123(6) *Public Health* 426.

Morris, N & Rothman, D (eds.), 1998. *The Oxford History of the Prison: The Practice of Punishment in Western Society*. Oxford (GBR): Oxford University Press.

Naylor, B, 2014. 'Human rights and respect in prisons: The prisoners' perspective' 31 *Law in Context* 84.

Niveau, G, 2007. 'Relevance and limits of the principle of "equivalence of care" in prison medicine' 33(10) *Journal of Medical Ethics* 610.

Noble -v- AUS (2016). Committee on the Rights of Persons with Disabilities *Views adopted by the Committee concerning communication No. 7/2012: Marlon James Noble v. Australia* UN doc CRPD/C/16/D/7/2012 (2 September 2016). Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2F16%2FD%2F7%2F2012&Lang=en> 10 Sep 2017.

Nomidou, A, 2013. 'Standards in mental health facilities - an in depth case study in Greece using the WHO QualityRights tool' 12(4) *Journal of Public Mental Health* 201.

NZL Gov, 2013. *Initial reports submitted by States parties under article 35 of the Convention: New Zealand*, UN doc CRPD/C/NZL/1, 1 October 2013. Geneva (CHE): United Nations. Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fNZL%2f1&Lang=en> 10 Sep 2017.

Pantea -v- ROM (2003). European Court of Human Rights *Case of Pantea v. Romania* Application no. 33343/96 (3 June 2003). Available <http://hudoc.echr.coe.int/eng?i=001-61121> 10 Jul 2017.

Patel, V, 2012. 'Global Mental Health: From Science to Action' 20(1) *Harvard Review of Psychiatry (Taylor & Francis Ltd)* 6. Available <http://search.ebscohost.com/login.aspx?direct=true&db=aph&AN=71713645&site=ehost-live>.

Patel, V & o'rs, 2011. 'A renewed agenda for global mental health' 378(9801) *The Lancet* 1441.

Pelletier, J & o'rs, 2013. 'The Global Model of Public Mental Health through the WHO QualityRights project' 12(4) *Journal of Public Mental Health* 212.

Perlin, M & Dlugacz, H, 2009. '"It's doom alone that counts": can international human rights law be an effective source of rights in correctional conditions litigation?' 27(5) *Behavioral Sciences & the Law* 675.

Plueckhahn, T; Kinner, S; Sutherland, G & Butler, T, 2015. 'Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare' 203(9) *Medical Journal of Australia* 359.

Pratt, D & o'rs, 2006. 'Suicide in recently released prisoners: a population-based cohort study' 368(9530) *Lancet* 119.

PRI & APT, 2015. Association for the Prevention of Torture, *Detention Monitoring Tool: Addressing risk factors to prevent torture and ill-treatment*, 2nd edition. Geneva (CHE): Penal Reform International. Available <https://www.penalreform.org/priorities/torture-prevention/preventive-monitoring/tools-resources/> 10 Sep 2017.

Reid, W, 2000. 'Offenders with Special Needs' 6(5) *Psychiatric Practice* 280. Available <www.reidpsychiatry.com/columns/15%20Reid%2009-00.pdf> 10 Sep 2017.

Renolde -v- FRA (2008). European Court of Human Rights *Case of Renolde v. France* Application no. 5608/05 (16 October 2008). Available <http://hudoc.echr.coe.int/eng?i=001-88972> 10 Sep 2017.

Rodriguez, S, 2007. 'The Impotence of Being Earnest: Status of the United Nations Standard Minimum Rules for the Treatment of Prisoners in Europe and the United States' 33(1) *New England Journal on Criminal & Civil Confinement* 61.

Salize, HJ; Dressing, H & Kief, C, 2007. Central Institute of Mental Health, *Mentally Disordered Persons in European Prison Systems - Needs, Programmes and Outcome (EUPRIS)*, Final Report, 31 October 2007. Mannheim (DEU): European Commission. Available

<http://ec.europa.eu/health/ph_projects/2004/action1/docs/action1_2004_frep_17_en.pdf> 11 Jul 2017.

Sander, G & Lines, R, 2016. 'HIV, Hepatitis C, TB, Harm Reduction, and Persons Deprived of Liberty: What Standards Does International Human Rights Law Establish?' 18(2) *Health and Human Rights Journal* 171. Available <https://www.hhrjournal.org/2016/11/hiv-hepatitis-c-tb-harm-reduction-and-persons-deprived-of-liberty-what-standards-does-international-human-rights-law-establish/> 10 Jul 2017.

Santora, L; Espnes, G & Lillefjell, M, 2014. 'Health promotion and prison settings' 10(1) *International Journal of Prisoner Health* 27.

Schlanger, M, 2017. *Prisoners with Disabilities: Individualization and Integration*, University of Michigan Public Law Research Paper No. 544, 14 March 2017. (forthcoming in Luna, Erik (ed) A Report on Scholarship and Criminal Justice Reform. Available <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2932940> 11 Jul 2017.

Schwitters, A, 2016. 'Health interventions in prisons: a literature review - Annex 4', in WHO (ed.) *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update*. Geneva (CHE): World Health Organization. Available <https://www.ncbi.nlm.nih.gov/books/NBK379683/>.

Seevers, R, 2016. Project, AVoIwDA, *Making Hard Time Harder*, Programmatic Accommodations for Inmates with Disabilities Under the Americans with Disabilities Act, 22 June 2016. Seattle (USA): Disability Rights Washington. Available <www.disabilityrightswa.org/sites/default/files/uploads/MakingHardTimeHarderPDF.pdf> 10 Sep 2017.

Semikhvostov -v- RUS (2014). European Court of Human Rights *Case of Semikhvostov v. Russia* Application no. 2689/12 (6 February 2014). Available <http://hudoc.echr.coe.int/eng?i=001-140404> 10 Sep 2017.

Shalev, S, 2014. 'Solitary confinement as a prison health issue', in Enggist, S, Møller, L, Galea, G & Udesen, C (eds.) *Prisons and Health*, pp27-35. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/__data/assets/pdf_file/0011/249194/Prisons-and-Health,-5-Solitary-confinement-as-a-prison-health-issue.pdf> 10 Sep 2017.

Smith, C, 2000. 'Healthy Prisons': A Contradiction in Terms?' 39(4) *The Howard Journal of Criminal Justice* 339.

Steadman, H; Monahan, J; Duffee, B & Hartstone, E, 1984. 'The Impact of State Mental Hospital Deinstitutionalization on United States Prison Populations, 1968-1978' 75(2) *J. Crim. L. & Criminology* 474.

Stevens, J, 2014. 'Changing cultures in closed environments: What works?', in Naylor, B, Debeljak, J & Mackay, A (eds.) *Human Rights in Closed Environments*, pp230. Sydney (AUS): Federation Press.

SWE Gov, 2012. *Initial reports submitted by States parties under article 35 of the Convention: Sweden*, UN doc CRPD/C/SWE/1, 18 September 2012. Geneva (CHE): United Nations. Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fSWE%2f1&Lang=en> 10 Sep 2017.

Teplin, L, 1983. 'The criminalization of the mentally ill: Speculation in search of data' 94(1) *Psychological Bulletin* 54.

Thakkar, A, 2015. Disability Hallmark Initiative (The United Nations Convention on the Rights of Persons with Disabilities and the right to health: Article 25), *Human Rights in Health Care: How can we develop and successfully implement human rights frameworks for health and medical programmes?*, Research Internship 2014-2015. Melbourne (AUS): University of Melbourne. Available <http://research.unimelb.edu.au/__data/assets/pdf_file/0015/2006340/Research-Internship-2014-ANSHITA-FINAL.pdf> 11 Jul 2017.

Thornberry, P, 2016. *The International Convention on the Elimination of All Forms of Racial Discrimination: A Commentary.* Oxford (GBR): Oxford University Press.

Till, A; Forrester, A & Exworthy, T, 2014. 'The development of equivalence as a mechanism to improve prison healthcare' 107(5) *Journal of the Royal Society of Medicine* 179.

UN, 1955. First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, *Standard Minimum Rules for the Treatment of Prisoners*, Approved by Economic and Social Council (resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977). Geneva (CHE): United Nations. Available <www.ohchr.org/EN/ProfessionalInterest/Pages/TreatmentOfPrisoners.aspx> 10 Sep 2017.

------, 1975a. General Assembly, *Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN doc A/RES/3452(XXX), 9 December 1975. New York (USA): United Nations. Available <www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/3452(XXX)> 10 Sep 2017.

------, 1975b. General Assembly, *Torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment*, UN doc A/RES/3453(XXX), 9 December 1975. New York (USA). Available <www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/3453(XXX)> 10 Sep 2017.

------, 1982. General Assembly, *Principles of Medical Ethics*, UN doc A/RES/37/194, 18 December 1982. New York (USA): United Nations. Available <www.un.org/documents/ga/res/37/a37r194.htm> 10 Jul 2017.

------, 1988. General Assembly, *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*, UN doc A/RES/43/173, 9 December 1988. New York (USA): United Nations. Available <www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/43/173> 10 Sep 2017.

------, 1990. General Assembly, *Basic Principles for the Treatment of Prisoners*, UN doc A/RES/45/111, 14 December 1990. New York (USA): United Nations. Available <www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/45/111> 10 Sep 2017.

------, 2008. Office of the United Nations High Commissioner for Human Rights, *The Right to Health*, Fact Sheet 31. Geneva (CHE): World Health Organisation. Available <www.ohchr.org/Documents/Publications/Factsheet31.pdf> 10 Sep 2017.

------, 2010. General Assembly, *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)*, UN doc A/RES/65/229, 21 December 2010. New York (USA): United Nations. Available <www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/65/229> 10 Sep 2017.

------, 2015. UN Office on Drugs and Crime, *Handbook on Dynamic Security and Prison Intelligence*, Criminal Justice Handbook Series, December 2015. New York (USA): United Nations. Available <https://www.unodc.org/documents/justice-and-prison-reform/UNODC_Handbook_on_Dynamic_Security_and_Prison_Intelligence.pdf> 11 Jul 2017.

------, 2016a. Subcommittee on Prevention of Torture and Other Cruel, IoDToP, *Analytical assessment tool for national preventive mechanisms*, UN doc CAT/OP/1/Rev.1, 25 January 2016. Geneva (CHE): United Nations. Available <www.ohchr.org/Documents/HRBodies/OPCAT/CAT-OP-1-Rev-1_en.pdf> 10 Sep 2017.

------, 2016b. Office of the High Commissioner for Human Rights, *Iran: Denial of adequate medical treatment to political prisoners unacceptable – UN rights experts*, 27 April 2016. Geneva (CHE): United Nations Available <www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=19886&LangID=E> 15 Sep 2017.

------, 2016c. Office of the High Commissioner for Human Rights, *Mauritania: UN experts concerned about situation of jailed human rights activists*, 19 October 2016. Geneva (CHE): United Nations. Available <www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=20699&LangID=E> 15 Sep 2017.

------, 2016d. General Assembly, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, Annex to UN doc A/RES/70/175, 8 Jan 2016. New York (USA): United Nations. Available <https://cdn.penalreform.org/wp-content/uploads/1957/06/ENG.pdf> 10 Sep 2017.

------, 2017. Office of Legal Affairs, *United Nations Treaty Collection (Status as at: 16-09-2017 07:30:36 EDT)*, CHAPTER IV: HUMAN RIGHTS (15. Convention on the Rights of Persons with Disabilities). New York (USA): United Nations. Available <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=iv-15&chapter=4&lang=en> 17 Sep 2017.

UNODC & WHO, 2013. *Good governance for prison health in the 21st century*, A policy brief on the organization of prison health. Copenhagen: World Health Organization Regional Office for Europe. Available <www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf?ua=1> 13 Sep 2017.

US Gov, 2016. Howard, J & o'rs, *The Importance of Medicaid Coverage for Criminal Justice Involved Individuals Re-entering Their Communities*, ASPE Issue Brief, 28 April 2016. Department of Health and Human Services. Available <https://aspe.hhs.gov/pdf-report/importance-medicaid-coverage-criminal-justice-involved-individuals-reentering-their-communities> 15 Sep 2017.

USA Gov, 2017. Office of the Inspector General, *Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness*, Evaluation and Inspections Division 17-05. Department of Justice. Available <https://oig.justice.gov/reports/2017/e1705.pdf#page=1> 10 Sep 2017.

van den Bergh, B; Plugge, E & Yordi Aguirre, I, 2014. 'Women's health and the prison setting', in Enggist, S, Møller, L, Galea, G & Udesen, C (eds.) *Prisons and Health*, pp159-164. Copenhagen: WHO Regional Office for Europe. Available <www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/publications/2014/prisons-and-health/report-by-chapters/chapter-18.-womens-health-and-the-prison-setting> 15 Sep 2017.

Vicary, D & Westerman, T, 2004. "That's just the way he is': some implications of Aboriginal mental health beliefs' 3(3) *Australian e-Journal for the Advancement of Mental Health* 103. Available <www.healthinfonet.ecu.edu.au/key-resources/bibliography?lid=2872> 10 Sep 2017.

WA Gov, 2008. Office of the Inspector of Custodial Services, *Inspection standards for Aboriginal prisoners*, Version 1, July 2008. Perth (AUS): Government of Western Australia. Available <www.oics.wa.gov.au/wp-content/uploads/2013/11/Final_Aboriginal_Prisoner_Standards_v_11.pdf> 10 Sep 2017.

Wainberg, M & o'rs, 2017. 'Challenges and Opportunities in Global Mental Health: a Research-to-Practice Perspective' 19(5) *Current Psychiatry Reports* 28.

Wenner -v- DEU (2016). European Court of Human Rights *Case of Wenner v. Germany* Application no. 62303/13 Available <http://hudoc.echr.coe.int/eng?i=001-165758> 10 Sep 2017.

WHO, 2012a. *QualityRights Tool Kit*, Assessing and improving quality and human rights in mental health and social care facilities. Geneva (CHE): World Health Organization. Available <www.who.int/mental_health/publications/QualityRights_toolkit/en/> 15 Sep 2017.

------, 2012b. *Social Protection Shared Interests in Vulnerability Reduction and Development.* Geneva.

Wilson, S, 2004. 'The principle of equivalence and the future of mental health care in prisons' 184(1) *The British Journal of Psychiatry* 5. Available <http://bjp.rcpsych.org/content/184/1/5> 10 Jul 2017.

Winkelman, T; Young, A & Zakerski, M, 2017. *Inmates are excluded from Medicaid – here's why it makes sense to change that*, 21 February 2017. Melbourne (AUS): The Conversation. Available <https://theconversation.com/inmates-are-excluded-from-medicaid-heres-why-it-makes-sense-to-change-that-71976> 10 Sep 2017.

WMA, 1975. World Medical Assembly, *Declaration of Tokyo – Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment*, (revised by the 67th WMA General Assembly, October 2016), October 1975. Tokyo. Available <https://www.wma.net/policies-post/wma-declaration-of-tokyo-guidelines-for-physicians-concerning-torture-and-other-cruel-inhuman-or-degrading-treatment-or-punishment-in-relation-to-detention-and-imprisonment/> 10 Sep 2017.

------, 1991. Assembly, WM, *Declaration of Malta on Hunger Strikers*, (revised by the 57th WMA General Assembly, October 2006). St. Julians (MLT). Available <https://www.wma.net/policies-post/wma-declaration-of-malta-on-hunger-strikers/> 10 Sep 2017.

------, 1993. Assembly, WM, *Statement on Body Searches of Prisoners*, (revised by the 67th WMA General Assembly, October 2016), October 1993. Budapest. Available <https://www.wma.net/policies-post/wma-statement-on-body-searches-of-prisoners/> 10 Sep 2017.

------, 1997. World Medical Association, *Declaration of Hamburg concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment*, (reaffirmed by the 176th WMA Council Session, May 2007), November 1997. Hamburg (DEU). Available <https://www.wma.net/policies-post/wma-declaration-of-hamburg-concerning-support-for-medical-doctors-refusing-to-participate-in-or-to-condone-the-use-of-torture-or-other-forms-of-cruel-inhuman-or-degrading-treatment/> 10 Sep 2017.

------, 2003. World Medical Association, *Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment*, (amended by the 58th WMA General Assembly, October 2007), September 2003. Helsinki. Available <https://www.wma.net/policies-post/wma-resolution-on-the-responsibility-of-physicians-in-the-documentation-and-denunciation-of-acts-of-torture-or-cruel-or-inhuman-or-degrading-treatment/> 10 Sep 2017.

Wolff, N & o'rs, 2007. 'Physical Violence Inside Prisons: Rates of Victimization' 34(5) *Criminal Justice and Behavior* 588.

Woodall, J, 2016. 'A critical examination of the health promoting prison two decades on' 26(5) *Critical Public Health* 615.

Woodall, J; de Viggiani, N; Dixey, R & South, J, 2014. 'Moving prison health promotion along: towards an integrative framework for action to develop health promotion and tackle the social determinants of health' 27(1) *Criminal Justice Studies* 114.

Woodall, J & Dixey, R, 2017. 'Advancing the health-promoting prison: a call for global action' 24(1) *Global Health Promotion* 58.

Wright, N; Jordan, M & Kane, E, 2014. 'Mental health/illness and prisons as place: frontline clinicians' perspectives of mental health work in a penal setting' 29 *Health & place* 179.

X -v- ARG (2014). Committee on the Rights of Persons with Disabilities *Views adopted by the Committee concerning communication No. 8/2012: Mr. X v Argentina* UN doc CRPD/C/11/D/8/2012 (11 April 2014). Available <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/11/D/8/2012&Lang=en> 10 Sep 2017.

Yale, 2016. Association of State Correctional Administrators & Arthur Liman Public Interest Program, *Aiming to Reduce Time-In-Cell*, Reports from Correctional Systems on the Numbers of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms, 30 November 2016. New

Haven (USA): Yale Law School. Available
<https://law.yale.edu/system/files/area/center/liman/document/aimingtoreducetic.pdf> 10 Sep 2016.